

1
FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06299

1. PLACE OF DEATH a. COUNTY <u>AACO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDEL - HOS</u>		d. STREET ADDRESS <u>2548 Hanford Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Nelson</u> Middle Last <u>Amy</u>		4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-05</u>
9. AGE (In years, months, days) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Calvin Amy</u>		14. MOTHER'S MAIDEN NAME <u>Edna V. ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Navy</u>		16. SOCIAL SECURITY NO. <u>086-16-2543</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer disease</u> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Short</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>5-4-66</u>	
EXAMINER'S NAME (Type) <u>F. Lin [Signature]</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/9/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Eugenia K. Seitz</u>		25a. REC'D BY REGISTRAR <u>Seitz Funeral Home</u>	
25b. REC'D BY SIGNATURE <u>[Signature]</u>		DATE <u>MAY 10 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil. When 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MADE IN U.S.A.

06304

CERTIFICATE OF DEATH

06300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 320 Burnside St.,	
3. NAME OF DECEASED (Type or print) First William Middle Wesley Last ATWELL		4. DATE OF DEATH Month May Day 1 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1903
9. AGE (In years last birthday) yrs. 63		10. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REFRIGERATION		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY ATWELL		14. MOTHER'S MAIDEN NAME MARY E. YOUNG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT EMMA V. ATWELL		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 16 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes; coronary artery disease; emphysema.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (deceased) attended the deceased from June , 19 66 to May 1 , 19 66 that (I) (saw) last saw the deceased alive on May 1 , 19 66 , and that death occurred at 4:00 AM M, from causes and on the date stated above.			
22a. SIGNATURE John L. Hedeman		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/2/66
22c. PHYSICIAN'S NAME (Type) John L. Hedeman, M.D.		22d. ADDRESS 1407 Forest Drive, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-4-66	23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS H.A. MD.
24. FUNERAL DIRECTOR John M. Long		25a. REC'D BY REGISTRAR MAY 4 1966	
25b. REGISTRAR'S SIGNATURE John Charles Judge			

1
FOR STATE
HEALTH DEPT.

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06305

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06301

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale		c. LENGTH OF STAY IN 1b 02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ferndale Police Station		e. STREET ADDRESS 10 Nann Avenue-Linthicum	
3. NAME OF DECEASED (Type or print) First CALVIN Middle C. Last AYERS		4. DATE OF DEATH Month May Day 4 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1925
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min. 0	
11b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11d. KIND OF BUSINESS OR INDUSTRY Local 1145	
11. BIRTHPLACE (State or foreign country) Mount Airy, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Ayers		14. MOTHER'S MAIDEN NAME Evelyn Meredith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korea		16. SOCIAL SECURITY NO. 223-28-1061	
17. INFORMANT Lois Laverne Ayers		Address 10 Nann Ave.-Linthicum	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hanging DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self.	
20c. TIME OF INJURY Month, Day, Year Hour 5/4 p.m. 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work Jail Cell	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ferndale		20f. (City or town) (County) (State) A.A. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.	
EXAMINER'S NAME (Type)		22. DATE SIGNED 5/5/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF May 5, 1966	
23c. NAME OF CEMETERY OR CREMATORY Elks Spur Cemetery		23d. LOCATION (City or Town) (County) (State) Mount Airy, North Carolina	
24. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS 1217 St. Paul Street	
25a. REC'D BY REGISTRAR MAY 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

8302

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1 (M)
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>P.O.A. - ANNE PRONDEL - General</u>		d. STREET ADDRESS <u>BRICIN ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>JANICE</u> Middle <u>E</u> Last <u>Badenhop</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-50</u>
9. AGE (In years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM H. BADENHOOP</u>		14. MOTHER'S MAIDEN NAME <u>GLADYS E. MENKE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>GLADYS E. BADENHOOP #2</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> <u>8194</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>car accident - truck struck bicyclist</u>	
20c. TIME OF INJURY Hour <u>8:00</u> p.m. Month, Day, Year <u>5/12 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>AA CO MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5/12/66</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-14-66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	22d. LOCATION (City, town, or country) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR <u>John M. Lythgoe</u>		24a. REC'D BY REGISTRAR <u>MAY 16 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

No —
 William H. Badenhop
 Gladys E. Badenhop #5
 Gladys E. Badenhop #5
 Gladys E. Badenhop #5
 Student School
 Baltimore Md. W.S.

Annaapolis Md
 3-14-10
 Willcrest
 Annaapolis Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL COUNTY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BROOKLYN PARK				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NORTH ARUNDEL GENERAL HOSPITAL					d. STREET ADDRESS 16 COACH LANE				
3. NAME OF DECEASED (Type or print) First Middle Last HENREITTA L. BAHR					4. DATE OF DEATH Month Day Year MAY 25, 1966				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 29, 1889		9. AGE (in years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME -----DINGES					14. MOTHER'S MAIDEN NAME ELIZABETH-----				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. MR. ALBERT R. BAHR, 5427 LEWELLEN AVE				
17. INFORMANT 21207					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1958 , to May 25, 1966 , that (I) (we) last saw the deceased alive on May 22, 1966 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE MORRIS W. STEINBERG					22b. DATE SIGNED 5/27/66				
22c. PHYSICIAN'S NAME (Type) MORRIS W. STEINBERG					22d. ADDRESS 3913 HOLLINS FERRY ROAD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-28-66		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY			23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVE. #29					25a. REC'D BY REGISTRAR MAY 31 1966				
					25b. REGISTRAR'S SIGNATURE Charles Judge				

FOR STATE
HEALTH DEPT

06308

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06304

1 PLACE OF DEATH a COUNTY <u>A. A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>MD</u> b COUNTY <u>Harford</u>	
b CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Harundale (Glen Burnie)</u>		c CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Harundale - Glen Burnie</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>S.O.A. - North ARUNDLE - Co.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>WARREN</u> Middle <u>S.</u> Last <u>Bailey</u>		4 DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/13/1898</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker (ret)</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Local - 122</u>	9 AGE (In years last birthday) <u>67</u> yrs
11 BIRTHPLACE (State or foreign country) <u>Balto. Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>WARREN S. Bailey</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>215-09-3972</u>	
17 INFORMANT <u>Lillian L. Bailey - Same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4341</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Autism</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o m p m		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)
20f (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. L. Shook</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED <u>5/27/66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5/31/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Brooklyn</u>
24. FUNERAL DIRECTOR <u>Singleton Funeral Home / Glen Burnie</u>		25a REC'D BY REGISTRAR <u>JUN 1 1966</u>	
ADDRESS <u>Robert P. P. P.</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

06309

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06305

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hilltop LANE</u>		d. STREET ADDRESS <u>Hilltop LANE</u>	
3. NAME OF DECEASED (Type or print) <u>KAETHE</u> First Middle Last		4. DATE OF DEATH <u>May 18 1966</u> Day Month Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-1904</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>HAMBURG GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HERMAN RICKERS</u>		14. MOTHER'S MAIDEN NAME <u>HUNNA WINKELMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>7712</u>	
17. INFORMANT <u>Mrs. FRED KOENIGER</u>		Address <u>148 WILDWOOD DR. ROCHESTER N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death due to stroke + pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Indefinite</u> DUE TO (b) <u>Indefinite</u> DUE TO (c) <u>Indefinite</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>5/18/66</u>	
EXAMINER'S NAME (Type) <u>F. L. [Signature]</u>		M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>5-20-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN</u>		23d. LOCATION (City, town or county) (State) <u>BLADENSBURG MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06310

CERTIFICATE OF DEATH

06306

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>				c. LENGTH OF STAY IN 1b <u>6/19/65 to 5/13/66</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINTHICUM</u>				d. STREET ADDRESS <u>5168 CAMP MEADE RD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KNOLLWOOD MANOR</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>CHARLES</u> Middle <u>BANGE</u> Last <u>BANGE</u>		4. DATE OF DEATH		Month <u>MAY</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY-22-1879</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ICE CREAM MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>EGG HARBOR, NJ.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>DANIEL BANGE</u>				14. MOTHER'S MAIDEN NAME <u>Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-20-6512</u>		17. INFORMANT <u>ADAM BANGE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ARTERIOSCLEROSIS MARKED</u> DUE TO (b) <u>PROBABLE RECURRENT TUMOR RIGHT</u> DUE TO (c) <u>INANITION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>?</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> , 19 <u>65</u> , to <u>5/13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Leymond W. Lott</u>				22b. DATE SIGNED <u>5/13/66</u>		22c. PHYSICIAN'S NAME (Type) <u>LEYMOND W. LOTT, MD.</u>	
22d. ADDRESS <u>529 CAMP MEADE RD. LINTHICUM</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 17, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>		24a. ADDRESS <u>Singleton Funeral Home</u>		24b. CITY <u>Green Belts, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>MAY 17 1966</u>					

FOR STATE
HEALTH DEPT.

0631

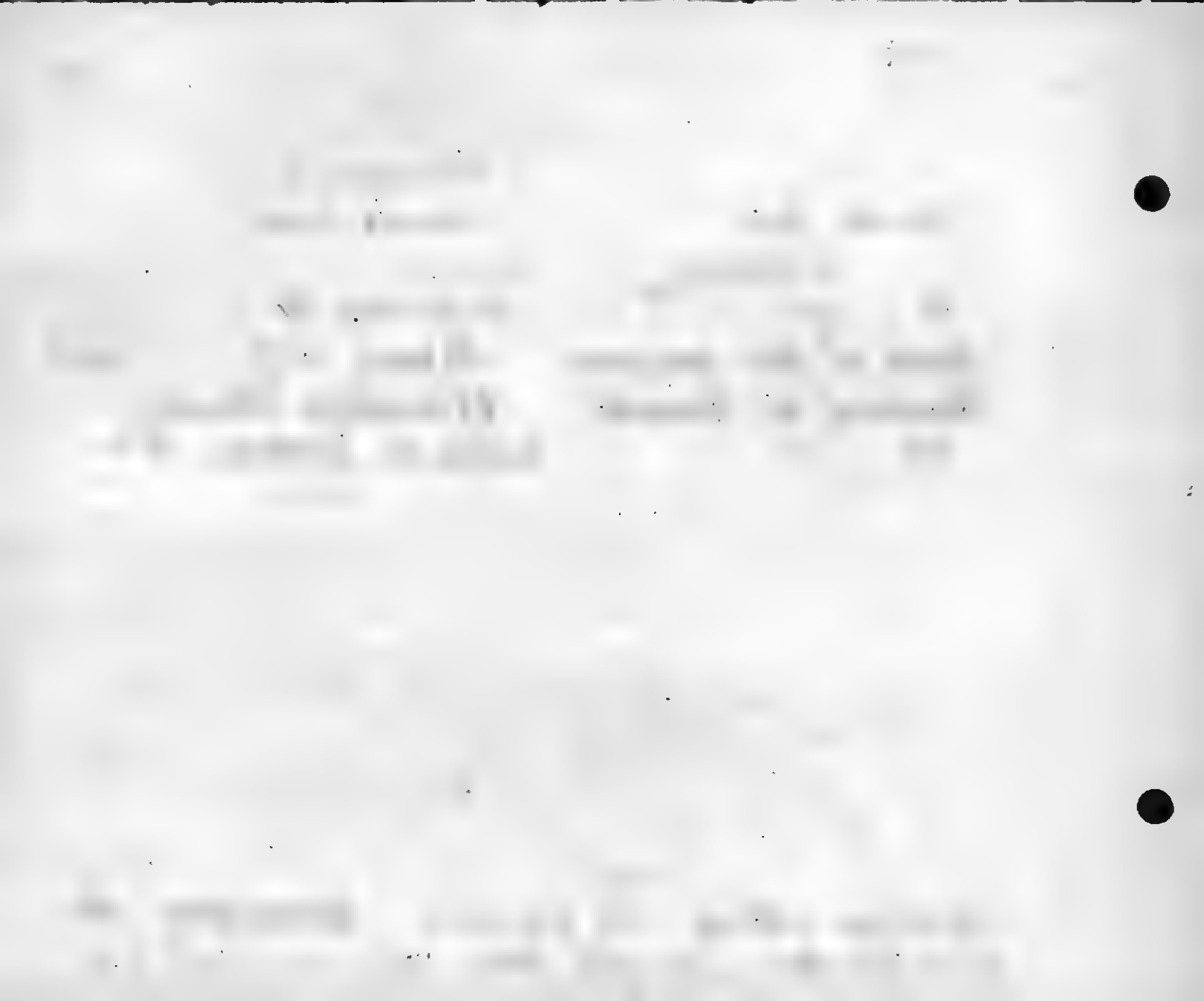
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06307

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1 BROOKE AVE</u>		d. STREET ADDRESS <u>1 BROOKE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>BARNES</u> Last <u>BARNES</u>		4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE OF MD. MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>ALBANY N.Y.</u>	
13. FATHER'S NAME <u>THURLOW W. BARNES</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH GLOVER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>101-11-1111</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self-inflicted Gun Shot wound Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Self-inflicted Gun Shot wound Skull</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5:15</u> a.m. <u>5/22</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>ANNAPOLIS MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		22. DATE SIGNED <u>5/22/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>5-23-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>BLADENSBURG MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Lyles & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06312					06308				
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>1 1st Ave. (W. Ferndale)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>MARTHA P. BARRY</u>			4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1966</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-06</u>		9. AGE (In years last birthday) <u>59</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Morris Parrish</u>					14. MOTHER'S MAIDEN NAME <u>Anno Day</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-16-6688</u>		17. INFORMANT <u>Mr. James Barry, Jr. (Husband)</u>			Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock.</u> DUE TO (b) <u>Septic Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Hypertensive Cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1.5 hours</u> <u>2 1/2 days</u> <u>4 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> , 19 <u>66</u> , to <u>5/30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> , 19 <u>66</u> , and that death occurred at <u>11</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Maurice J. Berman</u>					22b. DATE SIGNED <u>5/30/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>MAURICE J. BERMAN</u>					22d. ADDRESS <u>2. E. Read St. Balt. Md 21202</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>June 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>		
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>					25a. REC'D BY REGISTRAR <u>JUN 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

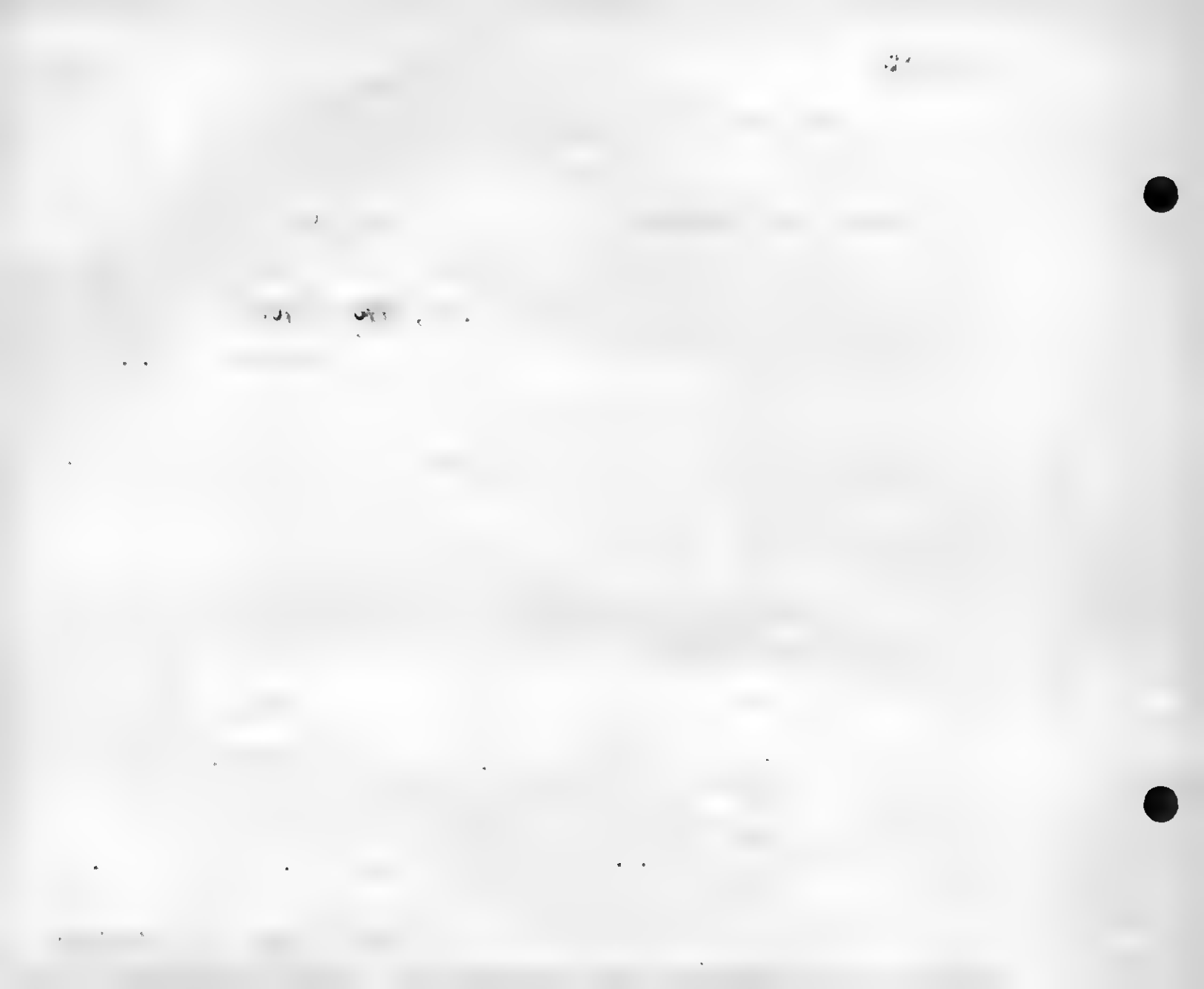


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Anne Arundel				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c LENGTH OF STAY IN 1b 13 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d STREET ADDRESS Happyland			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First John Middle BLAKE Last May					4 DATE OF DEATH Month May Day 2 Year 19 66				
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1887		9 AGE (In years last birthday) 79 YRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Memphis Tennessee		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Unknown					14 MOTHER'S M maiden name Unknown				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO		17 INFORMANT Martha Blake Odenton, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchitis Pneumonia, Bilateral 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ (c) _____ DUE TO								INTERVA. BETWEEN ONSET AND DEATH 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infirmities of old age, Cong. Heart failure									
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (Hospital) attended the deceased from 4/19/66 , 19 66 to May 2, 19 66 that (I) (us) last saw the deceased alive on May 2, 19 66 , and that death occurred at _____ M, from causes and on the date stated above.									
22a SIGNATURE Maurice Klawans					M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED 6:20 AM		
22c PHYSICIAN'S NAME (Type) Maurice Klawans, M.D.					22d ADDRESS 31 Southgate Ave., Annapolis, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)		
BURIAL			5-7-1966		MACEDONIA		Odenton, Md		
24. FUNERAL DIRECTOR William Reeseth					ADDRESS		25a. REC'D BY REGISTRAR MAY 3 1966		
							25b. REGISTRAR'S SIGNATURE John Judge		



CERTIFICATE OF DEATH

C6310

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>813 N. Milton Ave</u>	
3. NAME OF DECEASED (Type or print) <u>#28633</u> <u>Dennis</u> <u>M. Blumenstock</u>		4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/40</u>
9. AGE (In years last birthday) yrs <u>26</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>JEWELRY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin BLUMENSTOCK</u>		14. MOTHER'S MAIDEN NAME <u>Veronica</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-36-5675</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Crownsville</u>	20f. (City or town) (County) (State) <u>Md.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>64</u> , to <u>5/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/2/66</u> 19 <u>66</u> , and that death occurred at <u>6:10</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M. D.</u>		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22d. ADDRESS <u></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. Md.</u>
24. FUNERAL DIRECTOR <u>Stanley Miller - 2334 Jefferson St.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 6 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06315

CERTIFICATE OF DEATH

06311

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital (Dead on arrival)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Garfield NMN BLUNT			4. DATE OF DEATH Month Day Year May 27 19 66		
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1911	9 AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) A.A. Co Maryland	
13. FATHER'S NAME William Frank Blunt			14. MOTHER'S MAIDEN NAME Mollie Hutton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO. *****		17. INFORMANT Address Clara Selman Blunt Churchton, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Coronary artery atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (as physician) attended the deceased from April 1, 1966 , to May 27, 1966 , that (I) (we) last saw the deceased alive on May 27, 1966 , and that death occurred at 11:10 AM from causes and on the date stated above.					
22a. SIGNATURE John L. Hedeman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 28, 1966	
22c. PHYSICIAN'S NAME (Type) John L. Hedeman, M.D.		22d. ADDRESS 1407 Forest Drive, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/30/1966	23c. NAME OF CEMETERY OR CREMATORY Chews Memorial	23d. LOCATION (City or town) (County) (State) Churchton A.A.Co Md		
24. FUNERAL DIRECTOR ADDRESS C.E. Hicks, 111 Annapolis, Md			25a. REC'D BY REGISTRAR JUN 1 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

item 9 rlm G576 5/18/66 mh

CERTIFICATE OF DEATH

06316

06312

1. PLACE OF DEATH a. COUNTY Anne ARundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
c. LENGTH OF STAY IN 1b 1 yr. 4 mos.		d. STREET ADDRESS 528 - 24th St., N. E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Children's Center Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Michael Angelo Bowman		4. DATE OF DEATH Month Day Year May 12 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-48
9. AGE (In years last birthday) yrs. 17 1/8		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Catherine Bowman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO --	
17. INFORMANT Children's Center Hospital, Laurel, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Perforated duodenal ulcer DUE TO (b) Congenital heart disease DUE TO (c) Mental retardation and mongolism		INTERVAL BETWEEN ONSET AND DEATH 16 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 14, 1965 , to May 12, 1966 , that (I) (we) last saw the deceased alive on May 12, 1966 , and that death occurred at 8:40am , from causes and on the date stated above.			
22a. SIGNATURE <i>Margaret W. Mola</i>		22b. DATE SIGNED May 13, 1966	
22c. PHYSICIAN'S NAME (Type) MARGARET W. MOLA, M. D.		22d. ADDRESS Children's Center, Laurel, Md.	
23a. BURIAL, CREMATON, REMOVAL (Specify)	23b. DATE THEREOF 5-17-66	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet	23d. LOCATION (City or Town) (County) (State) Washington DC
24. FUNERAL DIRECTOR H.S. Washington & Sons		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 4925 Denne Ave		DATE MAY 16 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital						d. STREET ADDRESS Rt. 2 Box - 117				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAZZIE			First MAZZIE			Middle I.			Last BOYER		
4. DATE OF DEATH May 24 19 66			5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 27 Sept. 1892			9. AGE (In years last birthday) 83 yrs.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY XXXXXX Own Home		
11. BIRTHPLACE (County & State, or foreign country) Severn, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George Burner			14. MOTHER'S MAIDEN NAME Emily Stinchcomb		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. NONE			17. INFORMANT Bernice Stinchcomb, Same As # 2			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno-carcinoma anastis</u> 1750 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>May 19 66</u> , 19 <u>66</u> , to <u>5-23-</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-23-66</u> 19 <u>66</u> and that death occurred at <u>5 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>C. R. MacDonald</u>						22b. DATE SIGNED 5-26-66			22c. PHYSICIAN'S NAME (Type) C. R. MacDonald		
22d. ADDRESS 204 S/ Crain Hwy. Glen Burnie, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 27, 66			23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.			23d. LOCATION (City, town or county) (State) Howard Co., Maryland		
24. FUNERAL DIRECTOR <u>Robert Pugh</u> Singleton Funeral Home, Glen Burnie, Md.						25a. REC'D BY REGISTRAR MAY 31 1966			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
06315													
06314													
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u> c. LENGTH OF STAY IN 1b <u>8 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 1 Box 417</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u> d. STREET ADDRESS <u>Route 1 Box 417</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Myrne</u> Middle <u>Boyle</u> Last <u></u>						4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1966</u>							
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 28, 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				
13. FATHER'S NAME <u>Wesley Rightour</u>						14. MOTHER'S MAIDEN NAME <u>Martha Bryan</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Anna Robinson Gambrills, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT.</u> <u>501A</u> DUE TO (b) <u>CEREBRAL ATHEROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PYELONEPHRITIS.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>66</u> , to <u>APRIL</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>APRIL 28 1966</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Norman K. Bohrer</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Norman K Bohrer</u>						22d. ADDRESS <u>3201 Sage ave Belair-Bowie, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn</u>				23d. LOCATION (City, town or county) (State) <u>Johnstown Pa.</u>					
24. FUNERAL DIRECTOR <u>M. Gasch's Sons</u> <u>Hyattsville, Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

06319

CERTIFICATE OF DEATH

06315

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 815 Hill Top Road	
3 NAME OF DECEASED (Type or print) First Kenneth Middle Gerald Last BRATTON		4 DATE OF DEATH Month May Day 8 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 7, 1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) yrs 1 Months 1 Days 8 Hours 1 Min. 66
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Kenneth Gerald Bratton		14. MOTHER'S MAIDEN NAME Diane Susan Gunther	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 76x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, } (b) DUE TO (c) Prematurity			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from May 7 , 19 66 , to May 8 , 19 66 that (I) last saw the deceased alive on May 8 , 19 66 , and that death occurred at 8:45 PM M, from causes and on the date stated above.			
22a. SIGNATURE <i>Clayton Norton</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Clayton Norton, M.D.		22d. ADDRESS 48 BaltoAnna. Blvd., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 10, 1966	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk	23d. LOCATION (City or Town) (County) (State) Ritchie Hgwy Glen Burnie, Md
24. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hgwy, Balto, Md		25a. REC'D BY REGISTRAR MAY 11 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
66320					66316									
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie					b. COUNTY Anne Arundel									
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital					d. STREET ADDRESS 1664 Annapolis Road									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First MARY			Middle ELLA			Last BRENNAN			4. DATE OF DEATH Month May					
5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 25 Oct. 1899					
9. AGE (In years last birthday) 66 yrs.			10. BIRTHPLACE (County & State, or foreign country) Delaware			11. BIRTHPLACE (County & State, or foreign country) Delaware			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filler					10b. KIND OF BUSINESS OR INDUSTRY Ice Cream Plant					11. BIRTHPLACE (County & State, or foreign country) Delaware				
13. FATHER'S NAME Horace E. Stark					14. MOTHER'S MAIDEN NAME Lyda Altemous					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				
16. SOCIAL SECURITY NO. Unknown					17. INFORMANT Hilda M. Wilson - Same as # 2					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial coronary occlusion DUE TO (c) arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					20g. (County)					20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from March 3, 1966 to May 31, 1966 that (I) (we) last saw the deceased alive on May 23, 1966, and that death occurred at M, from the causes and on the date stated above.														
22a. SIGNATURE R. M. Smith										22b. DATE SIGNED 5/31/66				
22c. PHYSICIAN'S NAME (Type) R. M. Smith, M. D.										22d. ADDRESS Hahn Prof. Bldg., Severna Park, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 2 June 1966					23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				
23d. LOCATION (City, town or county) Pottsville, Pa.					23e. (State) Pa.									
24. FUNERAL DIRECTOR Robert P. Ware Singleton Funeral Home, Glen Burnie, Md.										25a. REC'D BY REGISTRAR JUN 1 1966				
25b. REGISTRAR'S SIGNATURE J. Charles Judge														



06321

CERTIFICATE OF DEATH

06317

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS 1420 Isted Rd. XXXXXX XXXX XXXX	
3. NAME OF DECEASED (Type or print) First Henry Middle Seymore Last BROWN		4. DATE OF DEATH Month May Day 16 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1875
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Presbyterian Ch.	
11. BIRTHPLACE (County & State, or foreign country) Rochester, New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Milton Brown		14. MOTHER'S MAIDEN NAME Cordelia Fletcher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Katharine U. How (daughter)		Address 3198 Overlook Dr. Warren, Ohio	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal Failure 0534 DUE TO (b) Grammy septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the undersigned) attended the deceased from May 16, 1966 , to May 16, 1966 , that (I) (we) last saw the deceased alive on May 16, 1966 , and that death occurred at 2:15 PM from causes and on the date stated above.			
22a. SIGNATURE Edwin Davis, Jr.		22b. DATE SIGNED 5/16/66	
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr. M.D.		22d. ADDRESS 100 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 19, 1966	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Richard V. Singleton		25a. DATE BY REGISTRAR MAY 19 1966	
25b. REGISTRAR'S SIGNATURE Glen Burnie, Md.		25c. REGISTRAR'S SIGNATURE John Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

P₁
P₂



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CROUNSVILLE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				d. STREET ADDRESS <u>817 N. WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CROUNSVILLE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>SALLY</u> <u>CANTOR</u> <u>BROWN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>15</u> Year <u>1966</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-1895</u>		9. AGE (in years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>JUMP CASTOR BROWN</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Lutie Richards Anne</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4-2-1 DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/21/63</u> 19 <u>63</u> to <u>5/15/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/13/66</u> 19 <u>66</u> , and that death occurred at <u>4:45</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Hollis Seunarine MD</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>HOLLIS SEUNARINE</u>		22d. ADDRESS <u>CROUNSVILLE STATE HOSPITAL</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cal</u>		23d. LOCATION (City, town or county) (State) <u>Brooklyn Md</u>			
24. FUNERAL DIRECTOR <u>Choy A. Wilson</u>		ADDRESS <u>1000 Broomfield Ave</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

MEDICAL CERTIFICATION

10

1. The first part of the
document is a list of
the names of the persons
who were present at the
meeting.

2. The second part of the
document is a list of the
subjects which were discussed
at the meeting.

3. The third part of the
document is a list of the
conclusions which were
reached at the meeting.

4. The fourth part of the
document is a list of the
actions which were decided
upon at the meeting.

5. The fifth part of the
document is a list of the
recommendations which were
made at the meeting.

6. The sixth part of the
document is a list of the
conclusions which were
reached at the meeting.

7. The seventh part of the
document is a list of the
actions which were decided
upon at the meeting.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

M

06323

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06319

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>N. Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Jumpers Hole Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank J. Burkhardt</u> First Middle Last		4. DATE OF DEATH <u>5</u> <u>31</u> <u>1966</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1892</u> 9. AGE (in years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John J. Burkhardt</u> 14. MOTHER'S MAIDEN NAME <u>Violet Lempke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>213-12-8963</u> 17. INFORMANT <u>Mrs. Elizabeth Burkhardt - same</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung, left</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1952</u> 19 <u>May 31</u> 1966 , that (I) (we) last saw the deceased alive on <u>5/31/66</u> 19 <u>5</u> PM , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles R. MacDonald M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald, M.D.</u>		22b. DATE SIGNED <u>5/31/66</u> 22d. ADDRESS <u>204 Crain Hwy. S., Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>June 4, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u> 23d. LOCATION (City, town or county) <u>Ritchie Hwy., A. A. Co., Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 6 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06326					06320				
Item 8 1111 6377					5/31/66 mb				
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURKLE</u>				c. LENGTH OF STAY IN ID <u>3 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21226</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NORTH ARUNDEL</u>					d. STREET ADDRESS <u>108 Greenland Beach Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OPHELIA</u> Middle <u>BURMEISTER</u> Last <u>MAY</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1966</u>						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-30-91</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home maker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>? Janyska</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Andrew G. Burmeister</u>		Address <u>110 Greenland Beach Rd Baltimore Md 21226</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>years</u>								INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dry Gangrene (R) Foot</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> , 19 <u>66</u> , to <u>5/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>66</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>William J. [Signature]</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William J. [Signature]</u>					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 23 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Augustines Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Elkridge, Maryland</u>		
24. FUNERAL DIRECTOR <u>George J. Gonce</u> ADDRESS <u>4001 Ritchie Hgwy Balto Md</u>					25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



06325

CERTIFICATE OF DEATH

06321

Item 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3446 Piedmont Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Helen</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1966</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>1888</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore MD</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Copper</u>		14. MOTHER'S MAIDEN NAME <u>Clara Elsey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-015578</u>		17. INFORMANT <u>MADE GUNNER</u> Address <u>3446 Piedmont Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>MI</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>67</u> to <u>MAY 28</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>MAY 28</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Hunt</u>				22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. HUNT</u>				22d. ADDRESS <u>100 Cherry Lane, Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>		<u>6-2-66</u>		<u>West Annapolis</u>			
23d. LOCATION (City, town or county)		23e. (State)		23f. (County)			
<u>Bethesda</u>		<u>Md.</u>		<u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mansoor P. Hays</u>				25a. REC'D BY REGISTRAR <u>Charles J. Jagger</u>			
25b. REGISTRAR'S SIGNATURE				25c. DATE <u>MAY 31 1966</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C6326

CERTIFICATE OF DEATH

C6322

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAND BEACH		c. LENGTH OF STAY IN lb WOODLAND BEACH RURAL ANNAPOLIS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ALFRED First CARRIERE Middle CARRIERE Last		4. DATE OF DEATH MAY Month 27 Day 19 Year 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29 1898 67 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRON WORKER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (County & State, or foreign country) MANITOBA CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ALFRED CARRIERE		14. MOTHER'S MAIDEN NAME ANGELE NAULT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 541-07-0942	
17. INFORMANT VICTORIA C. CARRIERE #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA DUE TO 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/6 , 19 66 to 5/27 , 19 66 , that (I) (we) last saw the deceased alive on 5/23 , 19 66 , and that death occurred at 5:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman M.D.		22b. DATE SIGNED 5/29/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, MD		22d. ADDRESS 59 Franklin St., Annapolis, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 31 1966	23c. NAME OF CEMETERY OR CREMATORY WASH. NATIONAL CEM.	23d. LOCATION (City or Town) (County) (State) SUITLAND P.G. CO MD
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD		25a. REC'D BY REGISTRAR JUN 1 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06327											
06323											
1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Churchton Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institut on; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Churchton Md.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Eleanor Chapman</u> First Middle Last 4. DATE OF DEATH <u>5</u> / <u>1</u> / <u>1966</u> Month Day Year						5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-28-1892</u> 9. AGE (In years last birth day) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?						13. FATHER'S NAME <u>Edward Isaac</u> 14. MOTHER'S MAIDEN NAME <u>Mary Wallace</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Eleanor Forrester Churchton</u> 17. INFORMANT <u>Shady Side, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIF. CANT. CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (b) <u>Bowel obstruction, cause unknown heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> year											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 63</u> to <u>May 1 66</u> , that (I) (we) last saw the deceased alive on <u>April 16 1966</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Willard F. Smith MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, MD</u> 22d. ADDRESS <u>Shady Side, Md.</u> 22b. DATE SIGNED <u>5/2/66</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>May 1 66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel Cemetery Md.</u> 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese # Anna</u> ADDRESS <u>Shady Side, Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>MAY 3 1966</u>											

06328

CERTIFICATE OF DEATH

06324

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Bristol	
3. NAME OF DECEASED (Type or print) First Zarick Middle Lee Last COATES		4. DATE OF DEATH Month May Day 26 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1966
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min 3	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.	
14. FATHER'S NAME John Edward Coates		15. MOTHER'S MAIDEN NAME Matilda Elizabeth Mason	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17. SOCIAL SECURITY NO	
18. INFORMANT Hospital records		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) renal enteritis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the doctor) attended the deceased from 5/25 , 19 66 , to 5/26 , 19 66 , that (I) (the doctor) saw the deceased alive on 5/25 , 19 66 , and that death occurred at 11:21 PM M, from causes and on the date stated above.			
22a. SIGNATURE Neil H. Sims		22b. DATE SIGNED 11:21 PM	
22c. PHYSICIAN'S NAME (Type) Neil H. Sims, M.D.		22d. ADDRESS 201 Forbes St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-29-66	23c. NAME OF CEMETERY OR CREMATORY Sollers	23d. LOCATION (City or Town) (County) (State) Bristol Md
24. FUNERAL DIRECTOR William Reese # Anna Mc		25a. REC'D BY REGISTRAR JUN 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no later than 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-66

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06329											
06326											
1. PLACE OF DEATH a. COUNTY <u>A.A.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 ARCHWOOD AVE</u>				d. STREET ADDRESS <u>112 ARCHWOOD AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u>		First		Middle <u>M.</u>		Last <u>COLE</u>		4. DATE OF DEATH <u>5</u> <u>9</u> <u>1966</u>		Month Day Year	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-1903</u>		9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REF</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>				11. BIRTHPLACE (County & State or foreign country) <u>N.Y.C. N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS J. COLE SR.</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN J. QUINN</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>ANN C. COLE #2</u>				17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute dilatation of the heart</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Parkinson's Disease</u> (c) <u>Parkinson's Disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> 19 <u>66</u> to <u>5/9</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/9</u> 19 <u>66</u> , and that death occurred at <u>5/9</u> M, from the causes and on the date stated above.				22a. SIGNATURE <u>Charles Judge</u>				22b. DATE SIGNED <u>5/9/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>John M. Taylor</u>				22d. ADDRESS <u>445 Mt. Gilead, Annapolis, MD</u>				22e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>5-12-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>			
23d. LOCATION (City, town, or county) <u>ANNAPOLIS</u>				23e. STATE <u>MD.</u>				23f. REC'D BY REGISTRAR <u>MAY 13 1966</u>			

06330

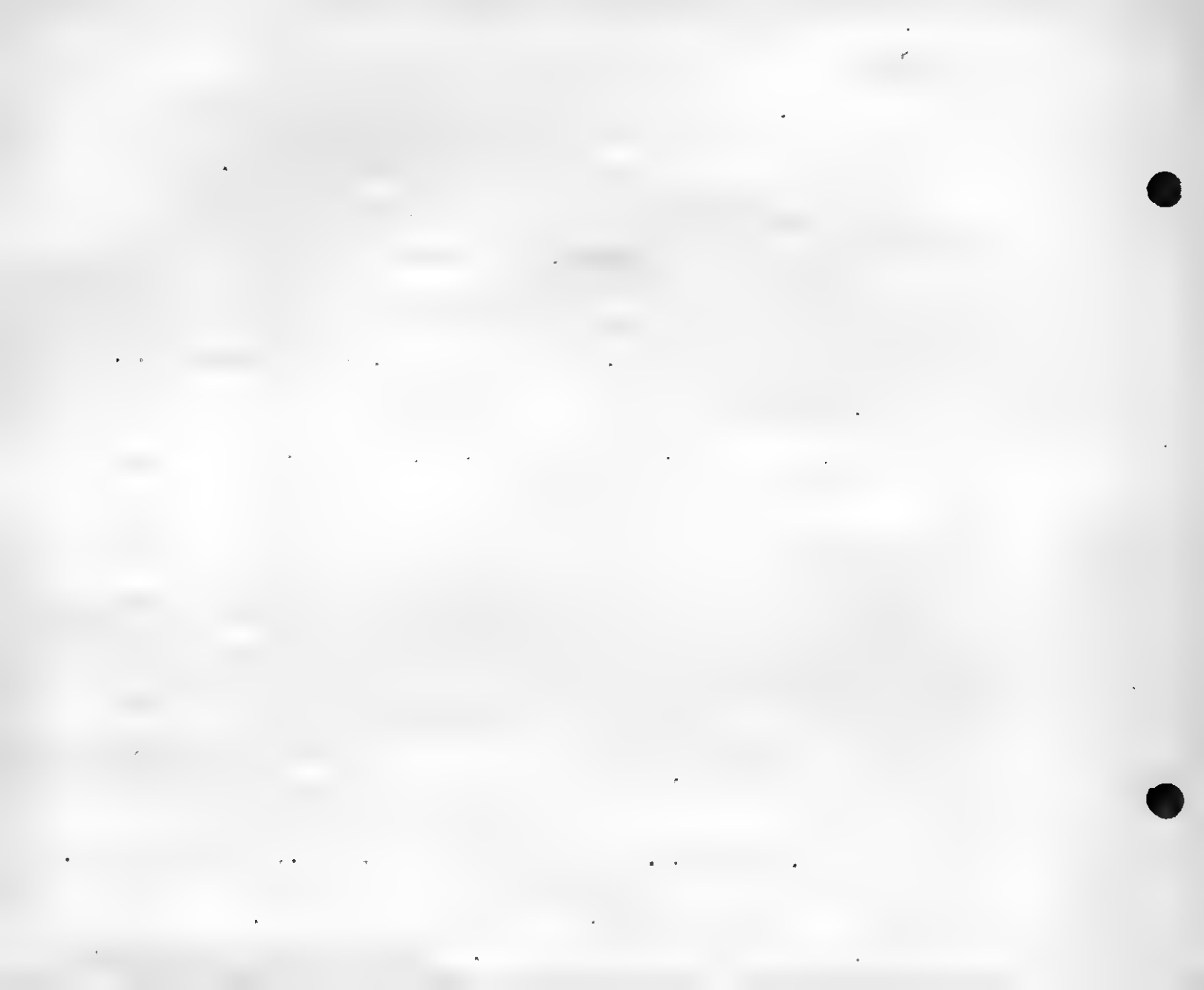
CERTIFICATE OF DEATH

06327

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please place in the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b 1 day	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park, Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d STREET ADDRESS 115 Arundel Beach Road	
3 NAME OF DECEASED (Type or print) First Walter Middle Dominic Last COLEMAN		4 DATE OF DEATH Month May Day 15 Year 1966	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 19, 1901
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleman		10b. KIND OF BUSINESS OR INDUSTRY Elgin Co.	
11. BIRTHPLACE (County & State, or foreign country) Balto. - Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter D. Coleman		14. MOTHER'S MAIDEN NAME Emma Kahl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I		16. SOCIAL SECURITY NO 214-18-5629	
17. INFORMANT Rosalie D. Coleman - Same as # 2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction 421 DUE TO (b) coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH few hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (one physician) attended the deceased from Jan , 19 66 , to May 15 , 19 66 , that (I) (we) last saw the deceased alive on May 15 , 19 66 , and that death occurred at 2:15 AM , from causes and on the date stated above.			
22a. SIGNATURE Ray M. Smith		22b. DATE SIGNED 2:15 AM	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M.D.		22d. ADDRESS Hahn Prof. Bldg., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/19/66	23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery	23d. LOCATION (City or Town) (County) (State) Balto. Maryland
24. FUNERAL DIRECTOR Singleton Funeral Home/ Glen Burnie, Md.		25a. REC'D BY REGISTRAR MAY 18 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge



1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06331 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					06328				
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis Maryland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ambrose</u>			First <u>Sebastian</u> Middle <u>Collins</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>II</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15, 1966</u>		9. AGE (in years last birthday) <u>26</u> yrs. <u>26</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis A.A. CO. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Collins</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Harried</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>N</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Margaret Harried</u> Address <u>Best Gate Rd. Lincoln Heights</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22. DATE SIGNED <u>5/11/66</u>	
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt, M.D., 3 Chesapeake Ave., Annapolis, Md.</u>					Address of City, Town, or County				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>May 13 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fowlers Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Best Gate Rd. Annapolis Md.</u>		
24. FUNERAL DIRECTOR <u>CHAS. E. Hicks III</u>					25a. REC'D BY REGISTRAR <u>MAY 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 23c, d, e, f, call from R.D. 5/9/66 mh

CERTIFICATE OF DEATH

1 PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Crownsville</u>		c LENGTH OF STAY IN lb <u>Balto.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>123 W. Hamburg St.</u>	
3. NAME OF DECEASED (Type or print) # <u>31777</u> <u>David</u> <u>Collins</u>		4 DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Sep.</u>	8. DATE OF BIRTH <u>April 15, 1900</u>
9. AGE (In years last birthday) yrs <u>66</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huckster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Tarboro N.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes W.W.I</u>		16 SOCIAL SECURITY NO. <u>212-40-2165</u>	
17 INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncopneumonia</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Bronchogenic Carcinoma</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration and Uremia</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/11/</u> , 19 <u>66</u> , to <u>5/9/</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>5/9/</u> , 19 <u>66</u> , and that death occurred at <u>11:45</u> M, from causes and on the date stated above.		22a. SIGNATURE <u>L. Benedict</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22b. DATE SIGNED <u>5/11/66</u>	
22d. ADDRESS <u>Crownsville, Maryland</u>		22e. ADDRESS <u>Crownsville, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 16, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto Md. Cedar Hill,</u>	
24. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>319 N. Schroeder St.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY AA				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 173 Meadow Rd.					d. STREET ADDRESS 173 Meadow Rd.				
3. NAME OF DECEASED (Type or print) First Sam Middle s Last Cowan					4. DATE OF DEATH Month 5 Day 19 Year 19 66				
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 27, 1875		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Charles Cowan					14. MOTHER'S MAIDEN NAME Eliz. Nesbitt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Pulmonary Cardiovascular Disease DUE TO (c) Stroke								INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from 19 May , 19 66 to SAME , 19 66 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 6:15 PM , from the causes and on the date stated above.									
22a. SIGNATURE Mario J. Reda					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) MARIO J. REDA M.D.					22d. ADDRESS 4016 RITCHIE HWY #21225				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/23/66		23c. NAME OF CEMETERY OR CREMATORY Fairview Cem.		23d. LOCATION (City, town or county) (State) Patton Pa.		
24. FUNERAL DIRECTOR McCully Funeral Home 237 Patapsco Ave.					25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

CERTIFICATE OF DEATH

06331

06334

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 14 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 600 Ridgley Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #31934		First Camilla		Middle H.		Last Cox	
4. DATE OF DEATH Month 5		Day 11		Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/14		9. AGE (In years last birthday) 51 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Thomas Guy				14. MOTHER'S MAIDEN NAME Sadie Mae			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus and Obesity</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/28/</u> , 1966, to <u>5/11/</u> , 1966, that (I) (we) last saw the deceased alive on <u>5/11/</u> , 1966, and that death occurred at <u>9: P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <i>Lionel McHenry Hopp</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/12/66			
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Hopp, M.D.		22d. ADDRESS Crownsville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/66		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR <i>Smiley E. Hopping</i>		ADDRESS HOPPING FUNERAL HOME		25a. REC'D BY REGISTRAR MAY 16 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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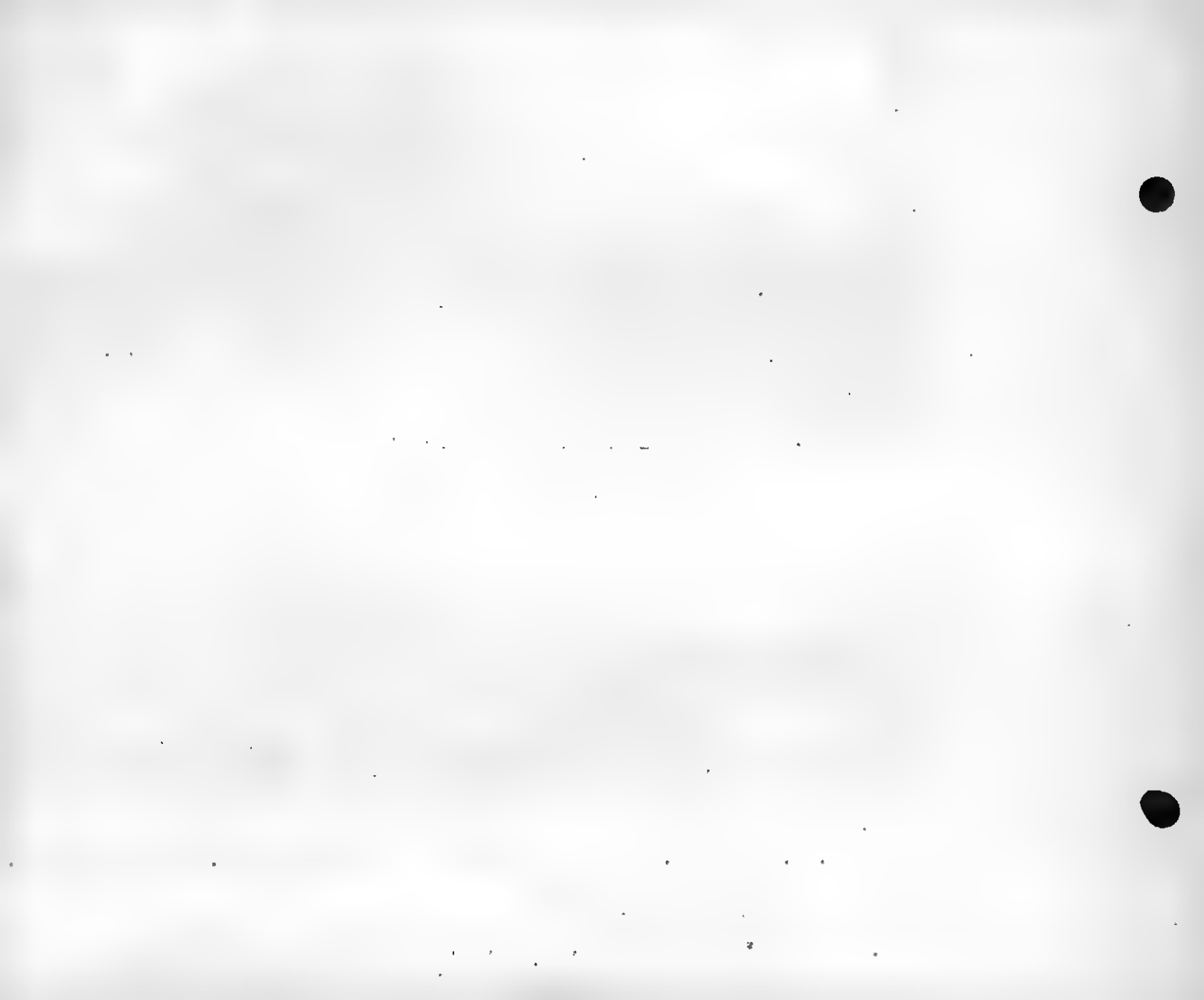
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M

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06335 CERTIFICATE OF DEATH 06332

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millersville c. LENGTH OF STAY IN b 9 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knollwood Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS Box 222A Magothy Beach e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Oliver B Crouch		4. DATE OF DEATH Month May Day 12 Year 1966	
5. SEX M	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draw Bridge Operator		12. KIND OF BUSINESS OR INDUSTRY Municipal Gov.	
13. FATHER'S NAME Oliver Crouch		14. MOTHER'S MAIDEN NAME ? Bennett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW #1		16. SOCIAL SECURITY NO. 212-05-2254	
17. INFORMANT Mrs Elizabeth Crouch		18. ADDRESS Box 222A Magothy Beach Pasadena, Maryland	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia left lower lobe 1221 DUE TO (b) arteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 13, 1966 to May 12, 1966 , that (I) (we) last saw the deceased alive on May 11, 1966 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE R. M. Smith		22b. DATE SIGNED MAY 17 1966	
22c. PHYSICIAN'S NAME (Type) R. M. Smith, M. D.		22d. ADDRESS Hahn Professional Bldg., Severna Pk., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16, 1966	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Frederick Ave. Balto, Md	
24. FUNERAL DIRECTOR George J. Gonce		25. REC'D BY REGISTRAR May 17 1966	
25a. ADDRESS 4001 Ritchie Hgwy, Balto, Md		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

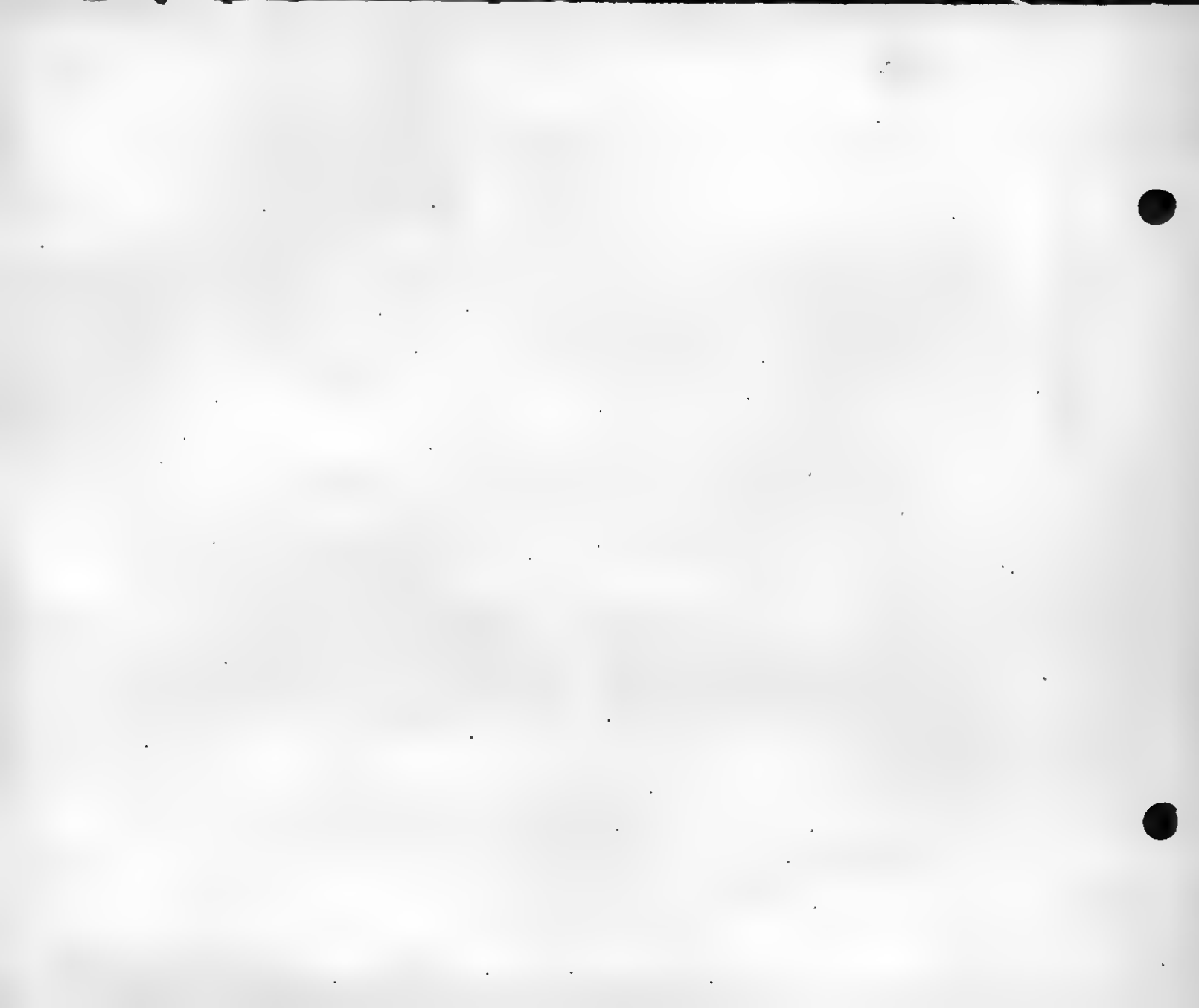
06336

CERTIFICATE OF DEATH

06333

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Ashley</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Burice</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ashley</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>722 Hazel St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Annapolis General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>L</u> Last <u>CUNNINGHAM</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-1913</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Dist. Maintenance School Dist.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>JOHN Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Murray, Catherine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mr Zawada</u>		Address <u>1028 Cape Dr Sea Breeze</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Ventricular Failure</u> DUE TO (b) <u>Acute Antero-lateral Myocardial Infarction</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1966</u> , to <u>May 1, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 1, 1966</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Max C Frank MD</u>		22b. DATE SIGNED <u>5/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>		22d. ADDRESS <u>425 E Ritchie Hwy. Glen Burnie Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 5, 1966</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Hanover Twp, Luz, Pa</u>
24. FUNERAL DIRECTOR <u>Robert P. Paine</u> ADDRESS <u>Singleton Funeral Home / 1414 Burview</u>		25a. REC'D BY REGISTRAR <u>MAY 5 1966</u>	25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06337

06334

1 PLACE OF DEATH a. COUNTY Anne Arundel County Maryland MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GENERAL HOSPITAL		d. STREET ADDRESS Edgewater Rt. 1 Box 409	
3 NAME OF DECEASED (Type or print) First Middle Last DORIS DANCY		4 DATE OF DEATH Month Day Year May 26 1966	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH
10a USUAL OCCUPATION (Give kind of work done during most of working life, even retired)		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 30 yrs.
11 BIRTHPLACE (State or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Dennis Melvin		14 MOTHER'S MAIDEN NAME Eutha Mae Owens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Eutha Mae Melvin Roseboro, N. C.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute alcoholism with methyl alcohol poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Apparently drank paint thinner	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5 26 1966	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f (City or town) (County) (State) Baltimore-Anne Arundel- Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breitenecker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 5/27/66			
23a BURIAL, CREMATION, or OTHER DISPOSAL (Specify) Burial	23b DATE THEREOF April 1, 1966	23c NAME OF CEMETERY OR CREMATORY Sam Spring	23d LOCATION (City or Town) (County) (State) Simpson Co. N. C.
24. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.		25a. REC'D BY REGISTRAR DATE MAY 31 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

06335

CERTIFICATE OF DEATH

06335

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY in lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Riva	
3 NAME OF DECEASED (Type or print) First William Middle EARL Last DASHIELL, Sr.		4. DATE OF DEATH Month May Day 21 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1901
9 AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 21 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE		10b. KIND OF BUSINESS OR INDUSTRY SALESMAN	
11. BIRTHPLACE (County & State, or foreign country) BALTO. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME CHARLES W. DASHIELL		14 MOTHER'S MAIDEN NAME STELLA ROSEN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17 INFORMANT MARGARET M. DASHIELL		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Pulmonary edema 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ac. Myocardial infarction DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 10 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) diabetes mellitus		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (do not know) attended the deceased from July , 19 52 , to May 21, 1966 , that (I) (do not know) last saw the deceased alive on May 20, 1966 , and that death occurred at 3:31 AM , from causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans M.D.		22b. DATE-SIGNED 5/23/66	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans, MD.		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-24-66	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR John M. G. Lottans Annapolis, Md.		25a. REC'D BY REGISTRAR MAY 26 1966	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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06339

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06336

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sovern DEALE d. STREET ADDRESS Box 8 - Rte. #256 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK		First W. DAVIS		Last DAVIS, Jr.		4. DATE OF DEATH Month May Day 1 Year 1966	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 20, 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sibley Hospital D.C.		9. AGE (In years last birthday) 2 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. <input checked="" type="checkbox"/>	
13. FATHER'S NAME FRANK W DAVIS				14. MOTHER'S MAIDEN NAME Bonnie Jean Goodrich			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute interstitial pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2x DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher		EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
				Address (Street, city, town, or county)		22. DATE SIGNED 5-2-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 5 1966		23c. NAME OF CEMETERY OR CREMATORY Woodfield		23d. LOCATION (City, town or county) (State) Laurel, Md.	
24. FUNERAL DIRECTOR Bernard O Hardesty		ADDRESS Laurel, Md.		25a. RECD BY REGISTRAR MAY 6 1966		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



CERTIFICATE OF DEATH

06340

06337

Item 23c Int. from 4/17/66-mh

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c LENGTH OF STAY IN lb 1 month		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Arnold	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d STREET ADDRESS Rt-1, Box-79,		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print*) First Mary Middle E. Last DAWSON		4. DATE OF DEATH Month May Day 11 Year 19 66		5 SEX Female		6 COLOR OR RACE White	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 8-18-70		9 AGE (In years last birthday) yrs. 95		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wm Lancaster				14. MOTHER'S MAIDEN NAME Sarah Portledge			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO no		17 INFORMANT Address Arthur Dawson - Above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1) Dementia 4221 DUE TO (b) 2) Congestive heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 3) a C.V.D.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10, 19 66 , to May 11, 19 66 that (I) (we) lost saw the deceased alive on May 11 19 66 , and that death occurred at M , from causes and on the date stated above.							
22a SIGNATURE Robert R. Hahn, M.D.				22b. DATE SIGNED 11:15 AM 5-11-66		22c. PHYSICIAN'S NAME (Type) Robert R. Hahn, M.D.	
22d ADDRESS Box-73, Severna Park, Md.		22e. REGISTRAR'S SIGNATURE Charles Judge					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-14-66		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d LOCATION (City or Town) (County) (State) Severna Park Md	
24 FUNERAL DIRECTOR Robert S. Baranov		24a ADDRESS Severna Park, Md		24b REC'D BY REGISTRAR MAY 16 1966		24c REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and notify event, within 72 hours after death.

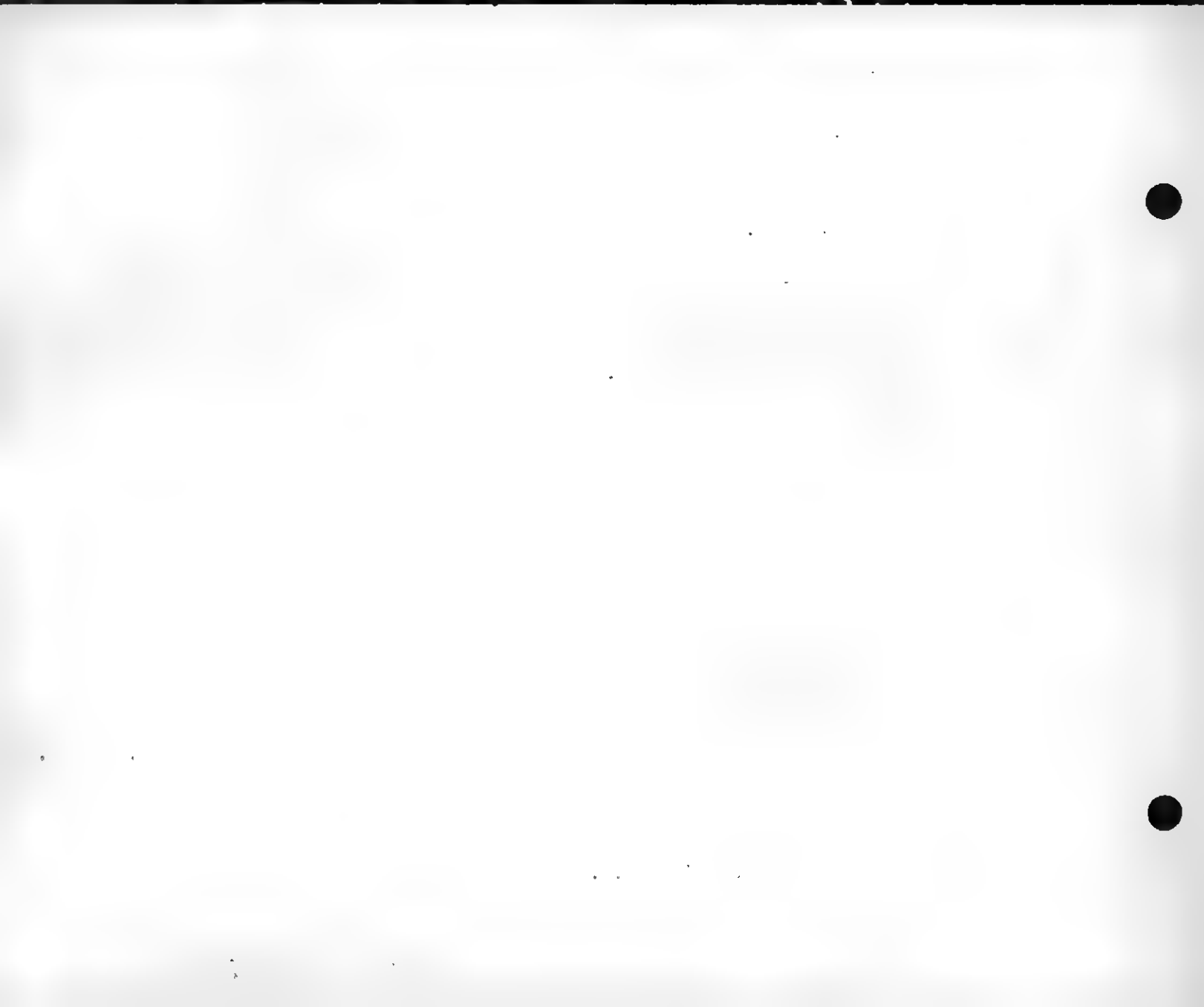


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
063341				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				06338			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY 4. 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn (Balto.-rural)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jackson Grove Rd.						d. STREET ADDRESS Rte. 1 Box 131				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle R. Last Denton						4. DATE OF DEATH Month 5 Day 30 Year 19 66					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 22, 1933		9. AGE (in years last birthday) 33 yrs		10. IF UNDER 1 YEAR Months 1 Days 30 Hours 19 Min 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener				10b. KIND OF BUSINESS OR INDUSTRY Landscaping		11. BIRTHPLACE (State or foreign country) Knoxville, Tennessee			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Claude Denton						14. MOTHER'S MAIDEN NAME Louisa McNish					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korean				16. SOCIAL SECURITY NO 214-30-4840		17. INFORMANT Mr. Cecil W. Denton (brother)			Address Same As #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumably drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fatty alteration of liver										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Undetermined							
20c. TIME OF INJURY Month Day Year Hour a.m. 5/30 19 66 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Jackson Gr. Rd., A.A., Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 5/31/66		
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
Address (Street, city, town, or county)						Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 1, 1966		23c. NAME OF CEMETERY OR CREMATORY Balto.-Nat'l. Ceme.				23d. LOCATION (City or Town) (County) (State) 1 Balto., Maryland			
24. FUNERAL DIRECTOR R.V. Singleton				ADDRESS Singleton Funeral Home				25. RECD BY REGISTRAR JUN 2 1966		25a. STRAIGHT SIGNATURE Johnnie Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06342

CERTIFICATE OF DEATH

06339

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm.) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1703 E. Madison St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>31958 Martha Dixon</u>				4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/8/08</u>	
9. AGE (In years last birthday) yrs. <u>58</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>	
10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jack Carter</u>				14. MOTHER'S MAIDEN NAME <u>Edith Pinnkett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-9473</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO (b) <u>Cirrhosis of Liver</u> DUE TO (c) <u>Chronic and Acute Alcoholism</u>							INTERVAL BETWEEN ONSET AND DEATH _____
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition and Dehydration</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>5/2/</u> , 19 <u>66</u> , to <u>5/11/</u> , 19 <u>66</u> , that (I) (we) last saw the deceased on an <u>5/11/</u> , 19 <u>66</u> , and that death occurred at <u>9: P.M.</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Linel McHenry Mapp, M.D.</u>				22d. ADDRESS <u>Crownsville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Westport Md</u>	
24. FUNERAL DIRECTOR <u>Joseph L. Raus</u>				ADDRESS <u>2222 W North Ave</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				DATE <u>MAY 19 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie.						c. LENGTH OF STAY IN 1b weeks					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel General Hospital						d. STREET ADDRESS #105 Hillendale Road					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First NELLIE			Middle GLENDON			Last EVANS		
4. DATE OF DEATH			Month MAY			Day 17			Year 1966		
5. SEX Female		6. GOLDR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1885		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret.)				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Wheeling, W. Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Glendon				14. MOTHER'S MAIDEN NAME Martha Terrill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 200 03 39008				17. INFORMANT Mrs. Irene Emery (daughter) Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 4-1-1 DUE TO Arterio Sclerotic Cardio-Vascular Disease Gonitions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 5-14- , 19 66 , to 5-17- , 19 66 , that (I) (we) last saw the deceased alive on 5-14- , 19 66 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE Ignas Saulynas											
22b. DATE SIGNED MAY 17, 1966											
22c. PHYSICIAN'S NAME (Type) Ignas Saulynas, M.D.											
22d. ADDRESS Balto.-Annap. Blvd., Glen Burnie, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 20, 1966				23c. NAME OF CEMETERY OR CREMATORY Southside Cemetery			
23d. LOCATION (City, town or county) (State) Pittsburgh, Pennsylvania											
24. FUNERAL DIRECTOR Richard V. Singleton											
25a. REG'D BY REGISTRAR MAY 18 1966											
25b. REGISTRAR'S SIGNATURE J. Charles Judge											



06344

CERTIFICATE OF DEATH

06341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS SHOREHAM BEACH			
3 NAME OF DECEASED (Type or print) First Leah Middle Pray Last FEY				4 DATE OF DEATH Month May Day 8 Year 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1893		9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months 8 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FRED BANKS				14. MOTHER'S MAIDEN NAME YUK PRAY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Stanley W. Fey #2 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4321 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular DUE TO (c) disease						INTERVAL BETWEEN ONSET AND DEATH 42 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral thrombosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) was not present attended the deceased from May 8 , 19 66 , to May 8 , 19 66 , that (I) was last saw the deceased alive on May 8 , 19 66 , and that death occurred at 4:10 PM , from causes and on the date stated above.							
22a. SIGNATURE Sylvia M. Lim M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/9/66	
22c. PHYSICIAN'S NAME (Type) Sylvia Lim, M.D.				22d. ADDRESS Mayo Road, Edgewater, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-11-66		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (City or Town) (County) (State) Switland MD.	
24. FUNERAL DIRECTOR John M. Lytle & Sons Annapolis, Md.				25a. REC'D BY REGISTRAR DATE MAY 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME
SM 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06345

06342

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1828 E. Eager Street	
3. NAME OF DECEASED (Type or print) James Fitzgerald 4. DATE OF DEATH 5 4 1966		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1923 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) 43 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Unknown 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Willie Fitzgerald 14. MOTHER'S MAIDEN NAME Annie Glover	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO Unknown 17. INFORMANT Hospital Records Address		18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a) Fracture, Base of Skull, Cerebral Softenings and Complications	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Accidental Fall on Street-Subsequent Operations and 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18, if applicable) Attacked 20c. TIME OF INJURY Month Day Year 1 66 19 Hour a.m. 1 p.m. 19 20d. INJURY OCCURRED Street 20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) Baltimore 20f. (City or town) (County) (State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Elmer G. Linhardt, M. D. EXAMINER'S NAME (Type) Elmer G. Linhardt, M. D.		DATE SIGNED 5/4/66 Address (Street, city, town, or county) 2431 E. Oliver St.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5-9-66 22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk. Arbutus, Md. 22d. LOCATION (City, town, or country) (State)		23. FUNERAL DIRECTOR Randolph J. Collick 24a. REC'D BY REG STRAR Charles Judge 24b. REGISTRAR'S SIGNATURE Charles Judge DATE MAY 10 1966	

CERTIFICATE OF DEATH

06343

06346

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A. Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>RIVA</u>	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Bay Manor Nursing Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE W. Galloway</u>				4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1880</u>		9. AGE (In years last birthday) yrs <u>86</u>	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FISH</u>		11. BIRTHPLACE (County & State, or foreign country) <u>RIVA, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>BEN. JAMES Galloway</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET McDONALD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>219 32 0495</u>		16. SOCIAL SECURITY NO. <u>219 32 0495</u>		17. INFORMANT <u>MARTHA L. Galloway</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>1810</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2-10</u> , 19 <u>66</u> , to <u>4-21</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>4-21</u> , 19 <u>66</u> , and that death occurred at <u>5:45</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-1-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>				22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RIVA</u>		23d. LOCATION (City or Town) (County) (State) <u>RIVA MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Lofgren & Sons Annapolis, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

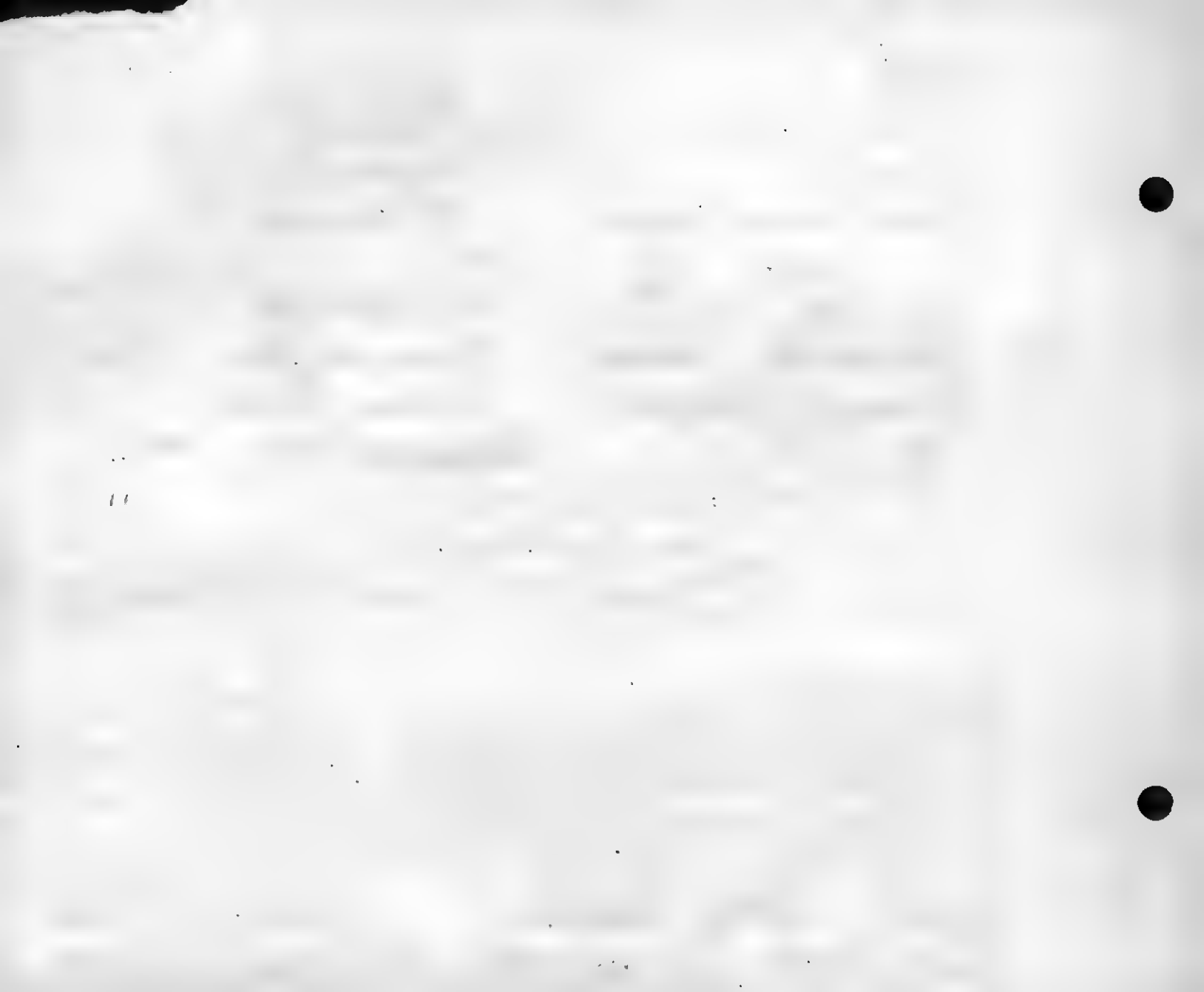
(T)

06347

CERTIFICATE OF DEATH

06346

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pendennis Mt.-Nr. Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General</u>		d. STREET ADDRESS <u>1917 Harwood Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>LEAH</u> Middle <u>B.</u> Last <u>GILLEY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1899</u>
9. AGE (In years last birthday) yrs <u>66</u>		10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR IND. STRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Janesville, Wis.</u>		12. CITY ZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Frederick Burpee</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Rowe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Donald C. Gilley</u>	
17. INFORMANT <u>Donald C. Gilley</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinomatosis, abdominal</u> DUE TO (c) <u>Primary carcinoma descending colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 WKS</u> <u>5 1/2 mo</u> <u>5 1/2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State) <u>-</u>
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 7</u> , 19 <u>65</u> , to <u>May 19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 18</u> , 19 <u>66</u> , and that death occurred at <u>1 A.</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Merton T. Waite</u>		22b. DATE SIGNED <u>M.D.</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Merton T. Waite, M.D.</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-23-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE</u>	23d. LOCATION (City or town) (County) (State) <u>Stoughton Wis.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06348

06345

1. PLACE OF DEATH a. COUNTY <u>ANN</u> <u>Crownsville</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Betty Sue Glass</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-1882</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Farwell</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Currier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Hugh M. Glass - 8469 Meadow Lane</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Sec. Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-12</u> , 19 <u>66</u> , to <u>5-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>66</u> and that death occurred at <u>8:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Hollis Seunarine, M.D.</u>		22b. DATE SIGNED <u>5/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hollis Seunarine</u>		22d. ADDRESS <u>Crownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>5/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Richmond Va</u>
24. FUNERAL DIRECTOR <u>John C. Miller, Inc. - 6415 Belair Rd.</u>		25a. REC'D BY REGISTRAR <u>MAY 17 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 File #G377 E/27/66

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE MARYLAND b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE	c. LENGTH OF STAY IN 1b 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 22	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CROWNSVILLE STATE HOSPITAL		d. STREET ADDRESS 3700 EDGEWATER	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First ROBERT Middle S. Last GLASS		4 DATE OF DEATH Month MAY Day 22 Year 1966	
5 SEX M	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/29/81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY —	9 AGE (In years last birthday) 85 yrs
11 BIRTHPLACE (County & State, or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ROBERT GLASS		14. MOTHER'S MAIDEN NAME MARY E. WHITE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Martin Alvey-633 Walker Ave. Balto.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DEHYDRATION & MALNUTRITION			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/20/66 , 19 66 , to 5/22/66 , 19 66 , that (I) (we) last saw the deceased alive on 5/22/66 , 19 66 , and that death occurred at 1030P M, from causes and on the date stated above			
22a. SIGNATURE Hollis Seunarine M.D.		22b. DATE SIGNED 5/22/66	
22c. PHYSICIAN'S NAME (Type) HOLLIS SEUNARINE		22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF May 24, 1966	23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematorium	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24 FUNERAL DIRECTOR H. Sander & Sons, Inc., Balto., Md.		25a. REC'D BY REGISTRAR MAY 25 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06350

06347

FOR STATE HEALTH DEPT

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GENERAL HOSPITAL		e. STREET ADDRESS Annapolis Terrace Motel		f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) RENE		4 DATE OF DEATH Month May Day 27 Year 1966							
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/3/43	9 AGE (In years lost birthday) yrs 23	10 IF UNDER 1 YEAR Months Days Hours Min				
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		11b KIND OF BUSINESS OR INDUSTRY		11c BIRTHPLACE (State or foreign country) Columbia, S. A.					
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Eugenio		14 MOTHER'S MAIDEN NAME Inge					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16 SOCIAL SECURITY NO 077-34-0666		17 INFORMANT Inge Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: Boeck's sarcoid IMMEDIATE CAUSE (a) 1380 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH					
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f (City or town)		20g (County)		20h (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Rudiger Breiteneker, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5/27/66					
EXAMINER'S NAME (Type) Rudiger Breiteneker, MD		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
23a BURIAL, CREMATION, REMOVAL (Specify) Buried		23b DATE THEREOF 5/29/1966		23c NAME OF CEMETERY OR CREMATORY New Montefiore					
23d LOCATION (City or Town) Farmersdale L.I. N.Y.		23e REC'D BY REGISTRAR MAY 31 1966		23f REGISTRAR'S SIGNATURE Charles Judge					
24 FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc.		ADDRESS 3319 Olympia							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06351		Item 1a reg. 277 6/9/66 mn						06348			
1. PLACE OF DEATH a. COUNTY <u>AA Co</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>ERIE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BUFFALO, New York</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Franklin Manor</u>						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <u>William OSGOOD GREENING</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIAGE STATUS <u>WIDOWED</u>		8. DATE OF BIRTH <u>MAY 30, 1904</u>		9. AGE (in years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BUFFALO, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FREDRICK GREENING</u>		14. MOTHER'S MAIDEN NAME <u>Lenieve OSGOOD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>GORDON GREENING</u>		Address <u>Churchton, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> 470 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u> <u>chronic alcoholism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> 19 <u>66</u> to <u>5/30</u> 19 <u>66</u> that (II) (we) last saw the deceased alive on <u>5/30</u> 19 <u>66</u> and that death occurred at <u>10 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Martin T. Kim, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>MARTIN T. KIM, M.D.</u>	
22d. ADDRESS <u>SHADY SIDE, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u> </u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
<u>BURIAL</u>		<u> </u>		<u> </u>		<u>EAST AURORA, New York</u>		<u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas A. Hardisty</u>						ADDRESS <u>Galesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

06352

06349

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Green Belvoir, Md.</u> c. LENGTH OF STAY IN 1b <u>Plaza Manor Nursing Home</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lothian</u> d. STREET ADDRESS <u>Box 35</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Louis</u>		First Middle Last <u>Griffin</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>8-3-1899</u>		9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboree</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>unknown</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U-S</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>218-36-2765</u>		17. INFORMANT <u>Mrs. Fearick Green Belvoir, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4271 DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (c) <u>Generalized Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>2-25</u> , 19 <u>66</u> to <u>5-12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-12</u> , 19 <u>66</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Richard H. Hunt</u> M.D. 22b. DATE SIGNED <u>5/13/66</u> 22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u> 22d. ADDRESS <u>100 Cherry Lane Green Belvoir, Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5-16-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Union</u> 23d. LOCATION (City, town or county) <u>Drumry Md.</u> (State) 24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese H. Arundel, Md.</u> ADDRESS 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>MAY 17 1966</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

06353

06350

1. PLACE OF DEATH a. COUNTY <u>H.A. Co.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Old Annapolis Blvd.</u>		e. STREET ADDRESS <u>Old Annapolis Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>Louis</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSERY - PLANTS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore MD.</u>	
13. FATHER'S NAME <u>JACOB GROSS</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>CATHERINE S. GROSS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emphysema</u> 5771 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 15</u> 19 <u>66</u> to <u>May 4</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>May 3</u> 19 <u>66</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John Hederman</u>		22b. DATE SIGNED <u>5/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN HEDERMAN</u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyons & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 9 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

06354

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06351

1 PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AACO</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - ANNIE ARONDEL - General L.</u>		d. STREET ADDRESS <u>1245 Madison St.</u>	
3. NAME OF DECEASED (Type or print) First <u>WARREN</u> Middle <u>Edwin</u> Last <u>HADAWAY</u>		4 DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-24-42</u>
9 AGE (In years) yrs <u>23</u>		10 IF UNDER 1 YEAR Months <u>17</u> Days <u>19</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technician</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>	
11 BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>WARREN N HADAWAY</u>		14 MOTHER'S MAIDEN NAME <u>ELSIE HEROLD</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>-</u>	
17 INFORMANT <u>MRS JEAN W. HADAWAY #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>auto accident - struck fixed object.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>PM</u> <u>5-12</u> 19 <u>66</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f (City or town) (County) (State) <u>ANAC MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		22. DATE SIGNED <u>5-17-66</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>5-15-1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>HILLCREST MEM.</u>	23d LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD</u>
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR SONS</u>		25a REC'D BY REGISTRAR <u>MAY 16 1966</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space for the signature of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06355

CERTIFICATE OF DEATH

06352

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 Month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 302 Chesapeake Ave.,	
3 NAME OF DECEASED (Type or print) First Middle Last Wesley MAN HALL		4. DATE OF DEATH Month Day Year May 22 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1893
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 22 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry - retired-U.S. Naval Academy		10b. KIND OF BUSINESS OR INDUSTRY Laundry - retired-U.S. Naval Academy	
11. BIRTHPLACE (City, state, or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John W. Hall		14. MOTHER'S MAIDEN NAME Rebecca Hensley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes N.A.		16. SOCIAL SECURITY NO 216-32-7168	
17. INFORMANT Carrie Hall-302 Chesapeake Ave. Anna. Md.		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart in coronary artery disease DUE TO (b) Hypertension in coronary artery disease DUE TO (c) Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVA. BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (i) (doctor) attended the deceased from June 8, 1966 , to May 22, 1966 , that (i) (doctor) last saw the deceased alive on May 22, 1966 , and that death occurred at M , from causes and at the date stated above.			
22a. SIGNATURE A. T. Allen		22b. DATE SIGNED 5/23/66	
22c. PHYSICIAN'S NAME (Type) A. T. Allen, M.D.		22d. ADDRESS 62 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF May 25-66	23c. NAME OF CEMETERY OR CREMATORY Baltimore National U.S.	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Maryland		25a. REC'D BY REGISTRAR MAY 26 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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M
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06356

06353

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		d. STREET ADDRESS <u>316 F Best Gate Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>Rebecca</u> Middle <u>HARRIS</u> Last		4. DATE OF DEATH <u>May</u> Month <u>6</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OF RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-1899</u> 67 yrs.
9. AGE (in years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>19</u> Hours <u>6</u> Min.	11. IF UNDER 24 HRS: Months <u>6</u> Days <u>19</u> Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Richard JONES</u>		14. MOTHER'S MAIDEN NAME <u>Margaret GREEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-05-2173</u>	
17. INFORMANT <u>John Harris - 316 F Best Gate Rd Annapolis</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coma and Acidosis</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 years +</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>66</u> to <u>May</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>May 6</u> 19 <u>66</u> , and that death occurred <u>8:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard Henry Mapp</u>		22b. PHYSICIAN'S NAME (Type) <u>Richard Henry Mapp, M.D.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Henry Mapp, M.D.</u>		22d. ADDRESS <u>20 Dean Street, Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5-10-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hopes Chapel Edgewater Md.</u>		23d. LOCATION (City, town, or County) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Young</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>		DATE <u>MAY 9 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06357

06354

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 9 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box-458, Cyril Ave.,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Ernest Middle Monroe Last HARTMAN		4 DATE OF DEATH Month May Day 13 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 27, 1909
9 AGE (In years last birthday) 57 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Die Maker	10b. KIND OF BUSINESS OR INDUSTRY Bendix Radio
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ARTHUR E HARTMAN		14. MOTHER'S MAIDEN NAME EMMA BECK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 216-05-1352	17. INFORMANT Mrs Lillian C Hartman Address Box 458, Cyril Ave Pasadena Maryland
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1777X DUE TO Myelofibrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Metastatic bronchogenic carcinoma DUE TO (b) DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death: 1 year			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (the doctor) attended the deceased from May 12, 1966 , to May 13, 1966 that (1) (the) last saw the deceased alive on May 13, 1966 , and that death occurred at 4:10 AM , from causes and on the date stated above.			
22a. SIGNATURE Gerard Church		22b. DATE SIGNED 5/13/66	22c. PHYSICIAN'S NAME (Type) Gerard Church, M.D.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 17, 1966	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park
24. FUNERAL DIRECTOR George J. Gonce		25a. REC'D BY REGISTRAR MAY 17 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
23d. LOCATION (City or Town) (County) (State) Ritchie Hgwy, Glen Burnie, Md			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06353

CERTIFICATE OF DEATH

06355

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>32 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>1518 Pennsylvania Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>#04214 Julia Harvey</u>		4 DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>--1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Unknown</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Hydrothorax</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Bronchogenic Carcinoma</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/19/</u> , 19 <u>34</u> , to <u>5/18/</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/18/</u> , 19 <u>66</u> , and that death occurred at <u>8:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>5/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>5/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Univ. of Maryland</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Reed</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>MAY 26 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, after any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06353

06356

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital (DOA)		d. STREET ADDRESS 14 Melroe Court, Apt., 102	
3. NAME OF DECEASED (Type or print) Robert		4. DATE OF DEATH May 23 1966	
5. SEX Male		6. COLOR OR RACE Cauc.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 10 December 1917	
9. AGE (In years) (If UNDER 1 YEAR, If UNDER 24 HRS. last birthday) Months Days Hours M.n. 48		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Platoon Sgt.	
11. BIRTHPLACE (State or foreign country) Columbiana, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert C. Helms		14. MOTHER'S MAIDEN NAME Alta Mc Intosh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1943-Present		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Helms (Wife)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Severe Coronary Sclerosis Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): Interval between onset and death	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Harold S. Wade		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Harold S. Wade		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF May 28, 1966	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or country) (State) Akron, Ohio	
23. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd. Laurel, Md		24a. REC'D BY REGISTRAR MAY 31 1966	
		24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

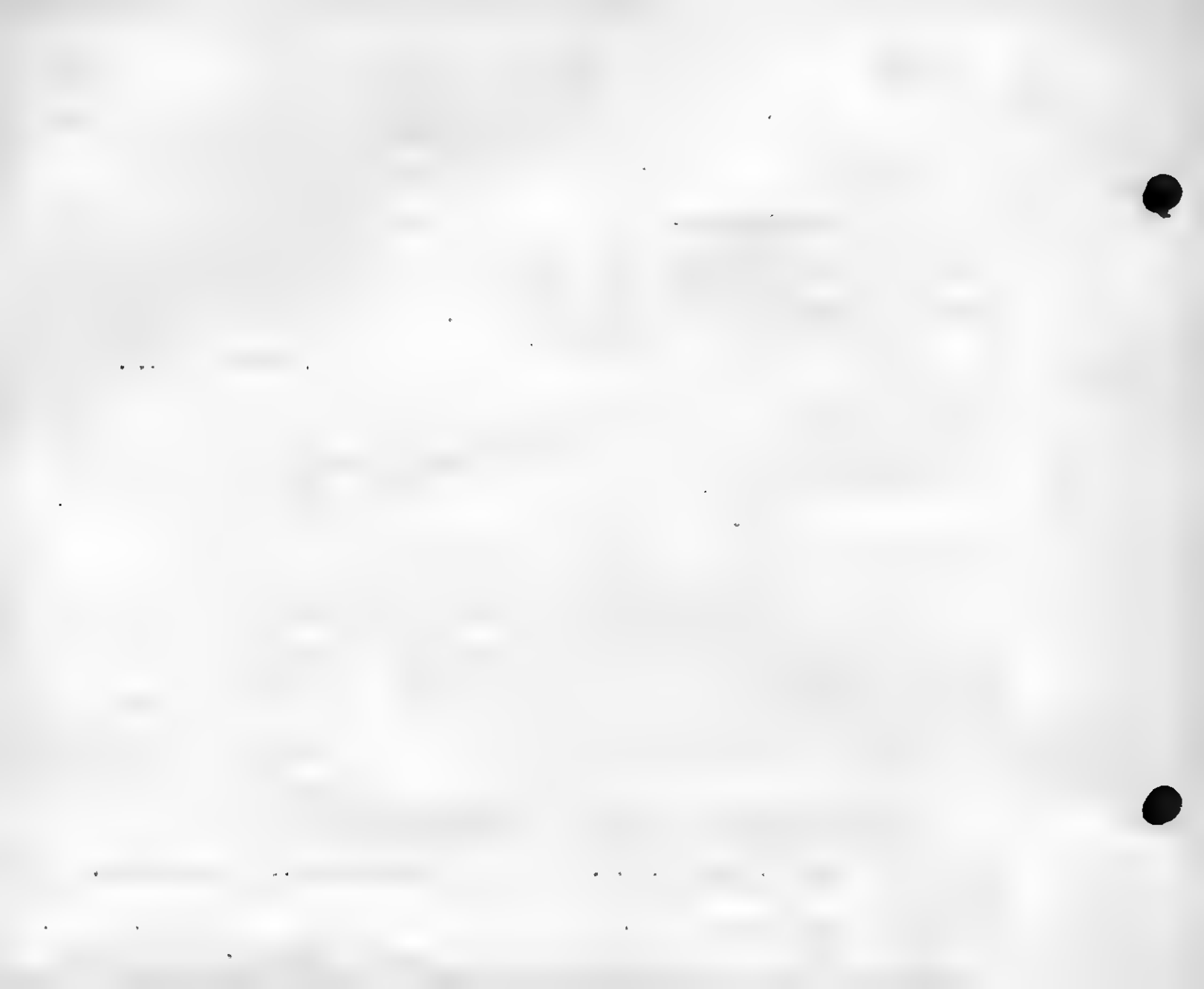
CERTIFICATE OF DEATH

06357

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Rutland Road	
3. NAME OF DECEASED (Type or print) First Amy Middle Linthicum Last HOPKINS		4. DATE OF DEATH Month May Day 2 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1883
9. AGE (In years lost birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. teacher		10b. KIND OF BUSINESS OR INDUSTRY grade school education	
11. BIRTHPLACE (County & State, or foreign country) Anne Arun. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Snowden Hopkins		14. MOTHER'S MAIDEN NAME Elizabeth Linthicum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO ---	
17. INFORMANT Miss Nancy Hopkins		Address same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Embolism 465X DUE TO (b) Diabetic Acidosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 2 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from 5-1-66 , 19 May 2 , 19 66 that (I) (va) last saw the deceased alive on May 2 , 19 66 , and that death occurred at 6:20 AM M, from causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 5-2-66	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 4, 1966	
23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		23d. LOCATION (City or Town) (County) (State) Millersville Md.	
24. FUNERAL DIRECTOR Berily & Hoping		25. REC'D BY REGISTRAR MAY 6 1966	
HOPPING FUNERAL HOME - Annapolis, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
06358														
1. PLACE OF DEATH a. COUNTY AA ANNE ARUNDEL MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY AA									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Burnie					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NORTH ARUNDEL Hospital					d. STREET ADDRESS Rt. 5-Box 23									
3. NAME OF DECEASED (Type or print) ALBERTA R. JACOB					4. DATE OF DEATH Month MAY Day 25 Year 1966									
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/3/21		9. AGE (In years last birthday) 44 yrs. XXX Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE WORK					10b. KIND OF BUSINESS OR INDUSTRY FRED E. VOGES CO.					11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.				
13. FATHER'S NAME MORRIS ROKOS					14. MOTHER'S MAIDEN NAME NELLIE NOVER					12. CITIZEN OF WHAT COUNTRY? USA				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 213-18-1880					17. INFORMANT MR. ROBERT E. JACOB, RT. 5 BOX 23				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 5-25-1966 to 5-25-1966 , that (I) (we) last saw the deceased alive on 5-25-1966 , and that death occurred at 7 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Charles Saulynas					22b. DATE SIGNED 5-25-66									
22c. PHYSICIAN'S NAME (Type) DR. SAULYNAS					22d. ADDRESS BALTIMORE, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 5-31-66					23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.				
23d. LOCATION (City, town or county) (State) BALTIMORE, MD.														
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVE. #2					25a. REC'D BY REGISTRAR MAY 31 1966					25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>26352</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>06359</div> </div>									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 412 Chesapeake Ave.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 412 Chesapeake Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FRANK nmn JOHNSON 4. DATE OF DEATH May 30 1966			5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 9-1886 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - General Utilities 10b. KIND OF BUSINESS OR INDUSTRY A.A.Co. Maryland 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Isaac Johnson 14. MOTHER'S MAIDEN NAME Hester Lane						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. (If yes give war or dates of service) 274-05-1444 17. INFORMANT Lola L. Johnson-412 Chesapeake Ave. Anna. Md Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from 10-28-66 , 19 , to 5-20-66 , 19 , that (I) (we) last saw the deceased alive on 5-26-66 , 19 , and that death occurred at 6:50 M, from the causes and on the date stated above. 22a. SIGNATURE A.T. Allen 22c. PHYSICIAN'S NAME (Type) A.T. Allen 22b. DATE SIGNED 5-20-66 22d. ADDRESS Cathedral St. Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF June 4-66 23c. NAME OF CEMETERY OR CREMATORY Brewer Hill 23d. LOCATION (City, town or county) (State) Annapolis, Maryland			24. FUNERAL DIRECTOR Charles E. Hicks 111 Annapolis, Maryland ADDRESS 25a. REC'D BY REGISTRAR JUN 2 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15 (4)
ISM 7-61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>AA</u> <u>Co.</u> <u>United</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Unincorporated</u> c. LENGTH OF STAY IN 1b <u>if live there</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>at Carlisle Dr - Unincorporated</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>AA</u> <u>C</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Unincorporated</u> d. STREET ADDRESS <u>at Carlisle Dr - Unincorporated</u>	
3. NAME OF DECEASED (Type or print) <u>HILDA E. Johnson</u>		4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-1886</u> 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retirement</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilhelm Ostman</u>		14. MOTHER'S MAIDEN NAME <u>Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>5-2-1-1886</u>	
17. INFORMANT <u>S. Mehl</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 week</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 16, 1966</u> to <u>May 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 16, 1966</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Rm Smith</u>		22b. DATE SIGNED <u>27 May 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. S. Smith</u>		22d. ADDRESS <u>1111</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5-28-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee F.H. Cemetery</u>		23d. LOCATION (City, town or county) <u>Washington, DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barker</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>10000</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 31 1966</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06364

CERTIFICATE OF DEATH

06361

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN TB 37 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 427 South Macyn St.	
3. NAME OF DECEASED (Type or print) #31914 Grace G. Jones		4. DATE OF DEATH Month May Day 31 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/91
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Tucker		14. MOTHER'S MAIDEN NAME Mattie Bohner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 1966	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/25/1966, to 5/31/1966, that (I) (we) last saw the deceased alive on 5/31/1966, and that death occurred at 10:30 M, from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 6/1/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-3-66	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION (City or Town) (County) (State) 7225 Eastern Blvd., Md.
24. FUNERAL DIRECTOR Charles S. Feiler		25a. REC'D BY REGISTRAR JUN 6 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. And, on any event, within 72 hours after death.

CERTIFICATE OF DEATH

06365

06362

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Rt-1, Box-113	
3. NAME OF DECEASED (Type or print) First Middle Last Henry Edward KALDENBACH		4. DATE OF DEATH Month Day Year May 11 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1908
9. AGE (In years last birthday) Yrs. 57		10. IF UNDER 1 YEAR Months Days Hours Min. 57	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CIT. ZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Superser Baker		14. MOTHER'S MAIDEN NAME Wells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 313105704	
17. INFORMANT Manan Kaldenbach		Address Abou	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 15:30 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastatic Carcinoma of Liver DUE TO (c) Carcinoma of Colon (Cecum)		INTERVAL BETWEEN ONSET AND DEATH 1 week unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (for hospital) attended the deceased from April , 19 66 , to May 11 , 19 66 , that (I) (for) last saw the deceased alive on May 11 , 19 66 , and that death occurred at 11:59 PM , from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED 13 May 66	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.		22d. ADDRESS SouthRivMedCent., Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-14-66	23c. NAME OF CEMETERY OR CREMATORY Eden Haven	23d. LOCATION (City or Town) (County) (State) Eden, Baltimore Md
24. FUNERAL DIRECTOR Robert S. Brumens, Severna Park		25a. REC'D BY REGISTRAR MAY 16 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

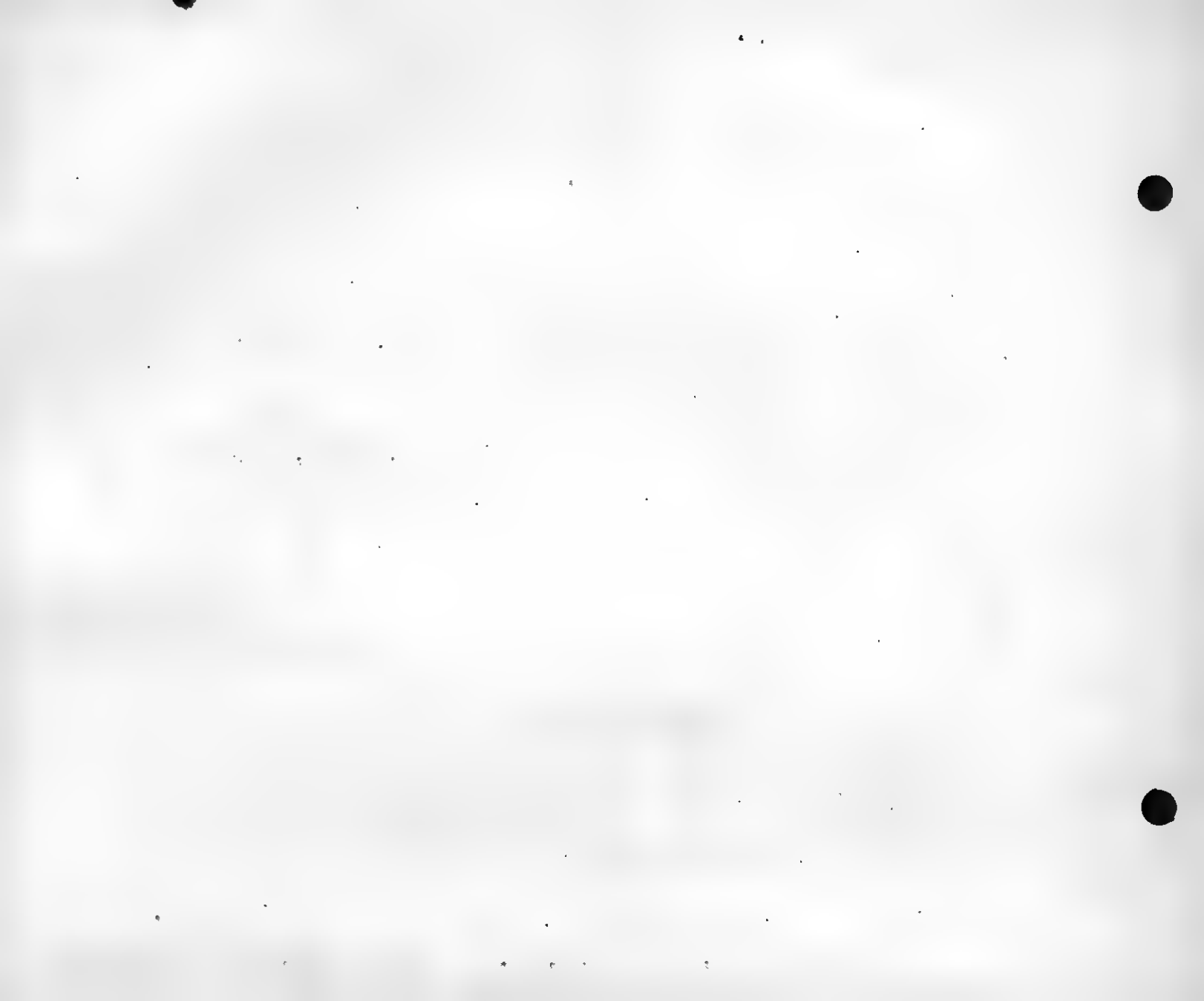
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>300k Ave</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, A.A.C.</u>	
c. LENGTH OF STAY IN 1b <u>25 yrs</u>		d. STREET ADDRESS <u>3 oak ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pasadena</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Amelia Kinder</u>		4. DATE OF DEATH <u>5-29-66</u> 19	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>MOX 15, 1885</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Julius Goukley</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Herman J. Kinder, same as 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 163X DUE TO (b) <u>Cor Pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Cor Lung.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>60</u> , to <u>1966</u> ; 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-29-66</u> 19 <u>66</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u>		22b. DATE SIGNED <u>5-29-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		22d. ADDRESS <u>P.O. BOX 73 Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2 June 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md. 21225</u>
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25. REC'D BY REGISTRAR <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06367

CERTIFICATE OF DEATH

06364

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Green Belton Md.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Paradene	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Annapolis Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle KOHLHAUFER Last KOHLHAUFER		4. DATE OF DEATH Month May Day 11 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 7 - 1896
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - NAVY C.O. Engr.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Frederick Kohlhafer		14. MOTHER'S MAIDEN NAME Emmie Kall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Sons	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Acute Myocardial Infarction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH hours hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 11, 1966 , to May 11, 1966 , that (I) (we) last saw the deceased alive on May 11, 1966 , and that death occurred at 4:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Max C Frank MD		22b. DATE SIGNED 5/11/66	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22d. ADDRESS 425 S. Ritchie Hwy Green Belton Md 21061	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-14-66	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	23d. LOCATION (City, town or county) (State) Belt 25
24. FUNERAL DIRECTOR McCully Funeral Home 237 Patapsco Ave		25a. REC'D BY REGISTRAR MAY 13 1966	
25b. REGISTRAR'S SIGNATURE J Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>8711 Baker Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>#26574</u> First <u>Walter</u> Middle <u>(WLADYSLAW)</u> Last <u>Kowalczyk</u>		4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-95</u>
9. AGE (in years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stevardure</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>215-09-3436</u>	
17. INFORMANT <u>E. KOWAL</u> <u>Hospital records</u>		Address <u>810 CLIFFEDEL RD.</u> <u>21208</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>12/19/194</u> , to <u>5/2/1966</u> , that (I) (we) lost saw the deceased alive on <u>5/2/1966</u> , and that death occurred at <u>6:15 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M. D.</u>		22b. DATE SIGNED <u>5/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-8-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balta. Md</u> <u>Balta Md.</u>
24. FUNERAL DIRECTOR <u>Wm. J. Kowalski</u>		25a. REC'D BY REGISTRAR <u>MAY 5 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (R)
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66366

1. PLACE OF DEATH a. COUNTY <u>A.A.Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRUMAN, MO. GLEN BURNIE D.O.A.</u>		c. LENGTH OF STAY IN 1b <u>Seven.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDEL - Hospital.</u>		e. STREET ADDRESS <u>Box 140 - Rt. 170</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>J</u> Last <u>KRAM. Sr.</u>		4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/1915</u>
9. AGE (In years last birthday) <u>50</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Subcontractor</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	
13. BIRTHPLACE (State or foreign country) <u>Ind.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Frederick Kram</u>		16. MOTHER'S MAIDEN NAME <u>Phyllis Potter</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		18. SOCIAL SECURITY NO <u> </u>	
19. INFORMANT <u>Carol Kram - 2012 Trilium Ave. Brit. 22, Ind.</u>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>Seven</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>5-3-66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>5/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's</u>	
23d. LOCATION (City or Town) (County) (State) <u>St. Ann's</u>		23e. LOCATION (City or Town) (County) (State) <u>Ind.</u>	
24. FUNERAL DIRECTOR <u>John Coxon, Inc. 901 N. Hollis St. Ind.</u>		25a. REC'D BY REGISTRAR <u>MAY 6 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

063670

06367

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park c. LENGTH OF STAY IN 1b 16 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) # 39 Boone Trail				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park d. STREET ADDRESS # 39 Boone Trail (instead) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMILY H. LAMCKE				4. DATE OF DEATH Month May Day 2 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1876	
9. AGE (In years last birthday) 89 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) New York City, N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Theodore Hesselmeyer		14. MOTHER'S MAIDEN NAME Jacoba D. Krebill		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Althea L. Wilson (daughter) as #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO (b) antehistiotic cardiovascular disease DUE TO (c) antehistiotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from April 30, 1966 to May 2, 1966 , that (I) (we) last saw the deceased alive on April 30, 1966 , and that death occurred at M , from the causes and on the date stated above.	
22a. SIGNATURE Ray M. Smith		22b. DATE SIGNED 5/2/66		22c. PHYSICIAN'S NAME (Type) Ray M. Smith M. D.		22d. ADDRESS Hahn Prof. Bldg., Severna Pk., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 4, 1966		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Co. Maryland	
24. FUNERAL DIRECTOR Richard V. Singleton		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR MAY 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

06368

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be removed from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY in 1b 9 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 21 West Washington St.			
3. NAME OF DECEASED (Type or print) First Middle Last Earnest William LANE				4. DATE OF DEATH Month Day Year May 2 19 66			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-1906		9. AGE (in years) 59 (last birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Const. Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Annapolis - Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Andrew Lane				14. MOTHER'S MAIDEN NAME Susanna Butler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-1591		17. INFORMANT Ruth Johns-10 carver St Anna. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 10 days 15 months Several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Cardiac failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from April 23, 19 66 , to May 2, 19 66 , that (I) (we) last saw the deceased alive on May 2, 19 66 , and that death occurred at 3:00 PM , from causes and on the date stated above.							
22a. SIGNATURE Sylvia M. Lim				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/3/66	
22c. PHYSICIAN'S NAME (Type) Sylvia Lim, M.D.				22d. ADDRESS Mayo Road, Edgewater, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 5-66		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City or Town) (County) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Md.				25a. REC'D BY REGISTRAR DATE MAY 9 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06372 CERTIFICATE OF DEATH 06369											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ARundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> d. STREET ADDRESS <u>403 South Hammonds Ferry Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u></u> Last <u>Lane</u>			4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>10-4-01</u>			9. AGE (In years last birthday) <u>25</u> yrs. Months <u>03</u> Days <u>03</u> Hours <u>00</u> Min. <u>00</u>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Findley, Ohio</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Alonzo Lane</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW 11</u>			16. SOCIAL SECURITY NO. <u>163-10-3772</u>			17. INFORMANT <u>Mabel Long Lane, same as 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> (b) <u>② Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fatty infiltration of Liver</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> , 19 <u>66</u> , to <u>5/28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-28</u> 19 <u>66</u> , and that death occurred at <u>1 A.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>H. T. O. Herlihy</u>											
22b. DATE SIGNED <u>5/28/66</u>											
22c. PHYSICIAN'S NAME (Type) <u>H.T.O. HERLIHY</u>											
22d. ADDRESS <u>5 Central Ave, Glen Burnie</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/31/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
23d. LOCATION (City, town, or county) (State) <u>Baltimore 25, Md.</u>				23e. REC'D BY REGISTRAR <u>JUN 1 1966</u>				23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home Glen Burnie, Md.</u>											



CERTIFICATE OF DEATH

06373

06370

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c LENGTH OF STAY IN 1a 3 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Dayie Middle Marie Last LEATHERBURY				4 DATE OF DEATH Month May Day 12 Year 19 66			
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 9, 1966		9 AGE (In years last birthday) yrs 2 Months 10 Days 35		IF UNDER 1 YEAR Months 2 Days 10 Hours 35
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn			10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.
13 FATHER'S NAME King Taylor Leatherbury				14. MOTHER'S MAIDEN NAME Linda Marie Heavener			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None		17 INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Immaturity DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 59 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from May 9, 19 66, to May 12, 19 66, that (I) (we) last saw the deceased alive on May 12, 19 66, and that death occurred at 4:15 AM M, from causes and on the date stated above.							
22a SIGNATURE Antonio M. Rivera				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 12 May 66	
22c. PHYSICIAN'S NAME (Type) Antonio M. Rivera, M.D.				22d ADDRESS SouthRivMedCent., Edgewater, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 5-13-1966		23c NAME OF CEMETERY OR CREMATORY Hillcrest		23d LOCATION (City or Town) (County) (State) Annapolis A.A. Md.	
24 FUNERAL DIRECTOR John M. Taylor & Sons				25a RECD BY REGISTRAR MAY 16 1966		25b REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If left unsealed, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

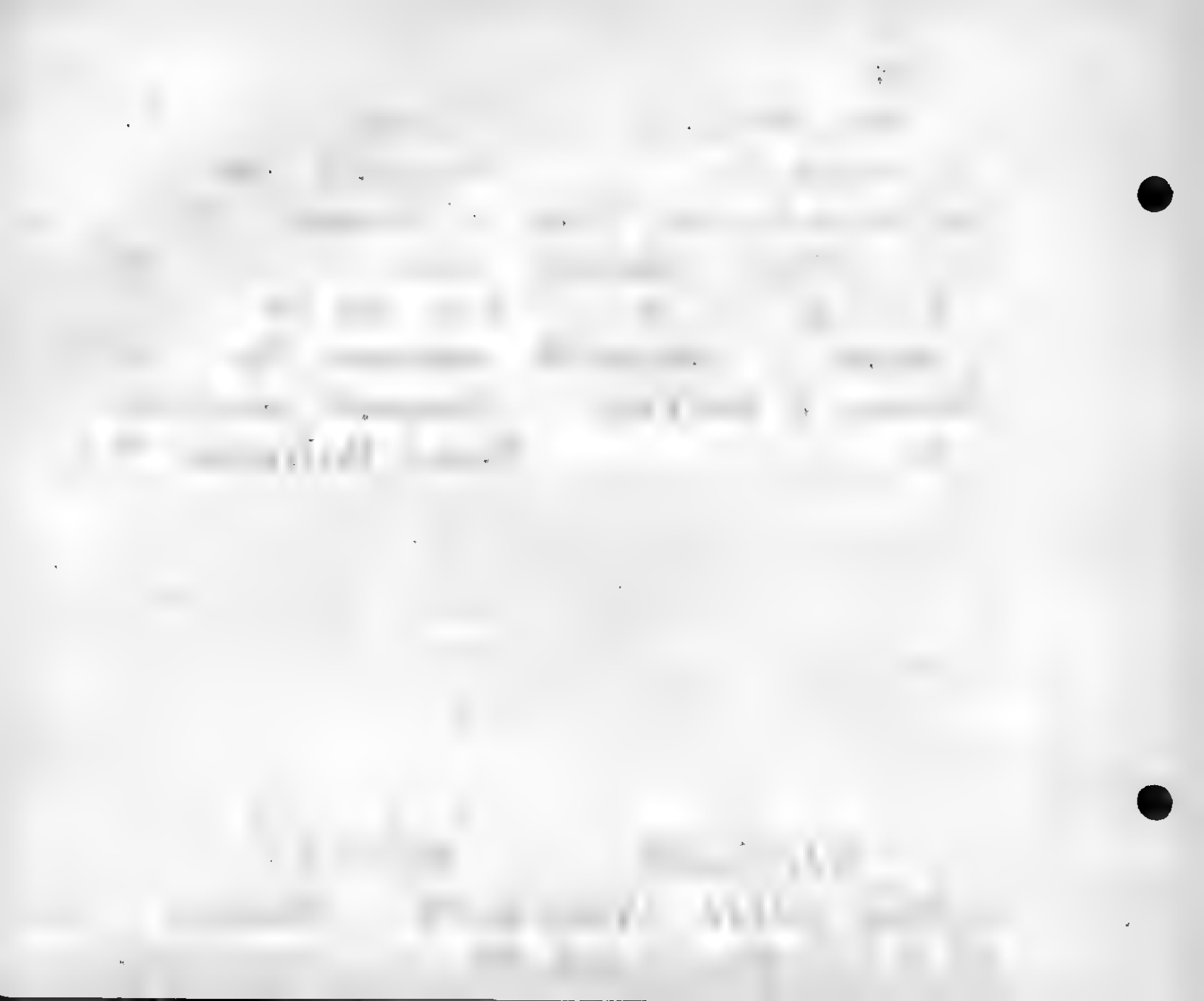
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06374		06371	
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Res. date before admission) a. STATE MD. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MARGARETS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS MD.	
d. NAME OF HOSPITAL, OR INSTITUTION (if not in hospital, give street address) BAY MANOR NURSING HOME		d. STREET ADDRESS 113 ACADEMY ST.	
3. NAME OF DECEASED (Type or print) First DORA Middle WARFIELD Last LEE		4. DATE OF DEATH Month 5 Day 25 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1882 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (County & State, or foreign country) HARMANS, MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME COLUMBUS R. WARFIELD		14. MOTHER'S MAIDEN NAME MARGARET HAWKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO HILDA L. MUSTERMAN #2	
17. INFORMANT HILDA L. MUSTERMAN		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction 4201 DUE TO (b) coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 65 , to May 25 , 19 66 , that (I) (we) last saw the deceased alive on May 24 , 19 66 , and that death occurred at 9:30 PM , from causes and on the date stated above.			
22a. SIGNATURE R. M. Smith		22b. DATE SIGNED May 24, 1966	
22c. PHYSICIAN'S NAME (Type) R. M. Smith		22d. ADDRESS ANNAPOLIS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5-28-66	23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR JUN 1 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

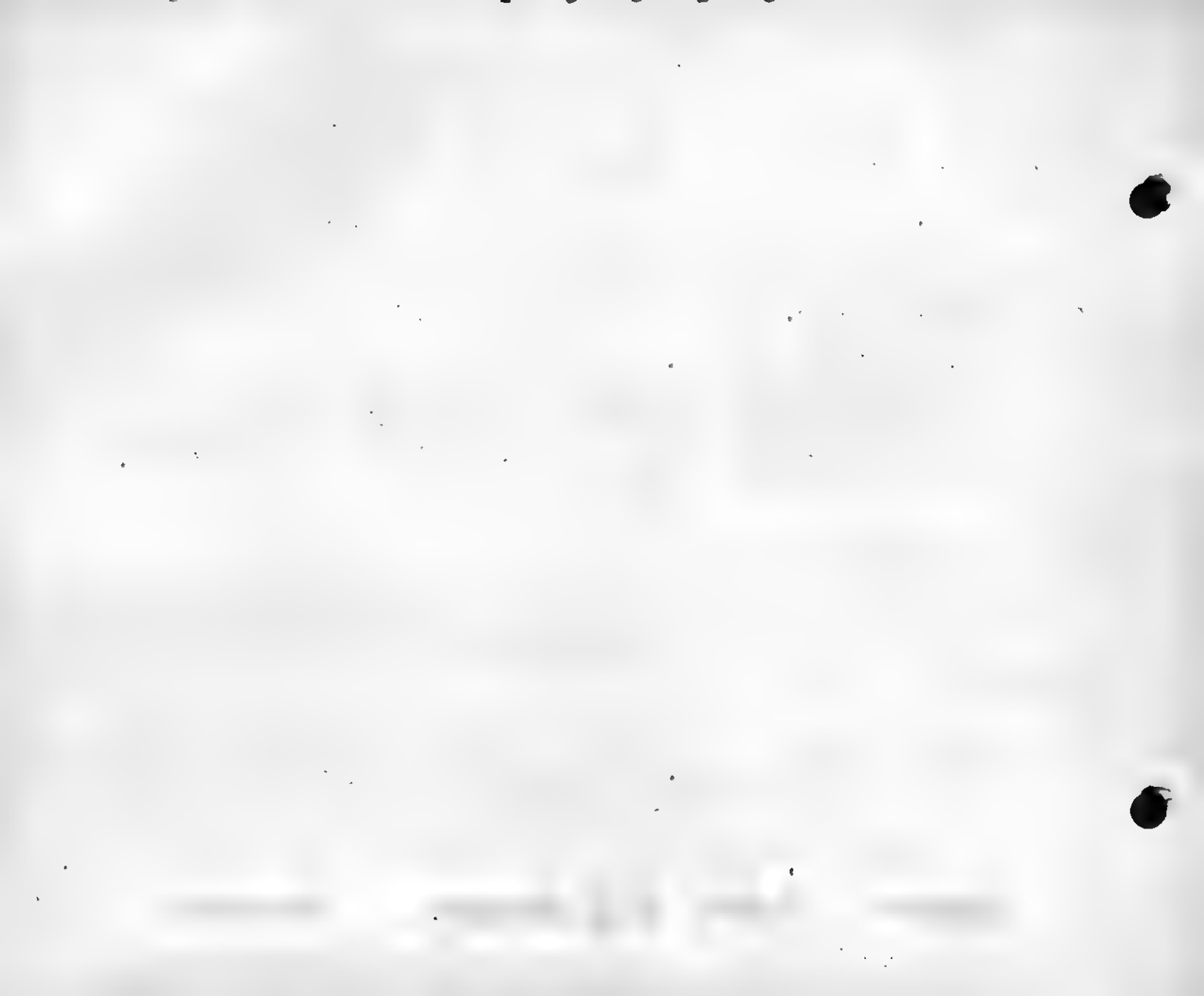
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
Item #106 Film #G3906/28/66 6/15/66 6/15/66 6/15/66 6/15/66 6/15/66 6/15/66 6/15/66 6/15/66 6/15/66 6/15/66									
63772									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>44</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>									
2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>Southgate 19 South Gate Avenue</u>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Chester "E" LEWIS</u>									
4. DATE OF DEATH Month Day Year <u>May 26 1966</u>									
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cauc.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <u>July 18, 1892</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Line Officer Retired U.S. Navy (Retired)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Lamira, Ohio</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>William Duff Lewis</u> 14. MOTHER'S MAIDEN NAME <u>Nanna L. Ramage</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>1915-1947-1011-1947</u> 17. INFORMANT (Wife) <u>Mrs. Lydia Lewis</u> Address <u>Southgate Ave. 19 South Gate Avenue Annapolis, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> 2001 DUE TO (b) <u>2001</u> DUE TO (c) <u>2001</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2001</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that <u>W</u> (this hospital) attended the deceased from <u>20 May</u> , 19 <u>66</u> , to <u>26 May</u> , 19 <u>66</u> , that <u>W</u> (we) last saw the deceased alive on <u>26 May</u> , 19 <u>66</u> , and that death occurred at <u>8:05</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>William P. Arentzen</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>26 May 1966</u>									
22c. PHYSICIAN'S NAME (Type) <u>Willard P. ARENTZEN, CAPT. MC USN</u> 22d. ADDRESS <u>U.S. Naval Hospital, Annapolis, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>5-31-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>U.S.N. ACADEMY</u> 23d. LOCATION (city, town or county) (State) <u>Annapolis Md.</u>									
24. FUNERAL DIRECTOR <u>John M. Taylor</u> 25a. REC'D BY REGISTRAR <u>John M. Taylor</u> 25b. REGISTRAR'S SIGNATURE <u>John M. Taylor</u>									



06376

CERTIFICATE OF DEATH

06373

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in one carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN ID 2 yrs. 10 mos. 27 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 1016 Baylis Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#25043 Alma		4. DATE OF DEATH Month 5 Day 23 Year 19 66		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1885	
9. AGE (In years lost birthday) yrs 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm & Factory		11. BIRTHPLACE (County & State, or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME August Neff		14. MOTHER'S MAIDEN NAME Johanna	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - Terminal DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Small Decubitus Ulcers		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Small Decubitus Ulcers		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 5 Day 19 Hour a.m. 7 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 3/26 , 19 63 to 5/23 , 19 66 that (I) (we) last saw the deceased alive on 5/23 , 19 66 and that death occurred at 9:30 A.M. from causes and on the date stated above.		22a. SIGNATURE Lionel McHenry Mapp	
22b. DATE SIGNED 5/23/66		22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5/25/66		23c. NAME OF CEMETERY OR CREMATORY Univ. of Maryland	
23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		24. FUNERAL DIRECTOR Wm. Reese		25a. REC'D BY REGISTRAR WAY 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 108 W. Wash. St. Annapolis, Md.		25d. REC'D BY REGISTRAR WAY 26 1966	



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil at the top. 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06377

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06374

1 PLACE OF DEATH a. COUNTY <u>M.D. CO.</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>M.D. CO.</u>		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Jacobsville</u>			c. LENGTH OF STAY N 1b <u>1.5</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DDA-NORTH HANDEL- Hosp.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>LEE</u> Middle <u>MACCOLL</u> Last <u>JR.</u>			4 DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1966</u>		
5 SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-64</u>	9 AGE (n years last birthday) <u>1</u> Yrs	10 F UNDER 1 YEAR Months <u>10</u> Days <u></u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>M.D. CO. MD</u>
13. FATHER'S NAME <u>JAMES LEO MACCOLL SR</u>			14. MOTHER'S MAIDEN NAME <u>MARCIET MARSHALL</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16 SOCIAL SECURITY NO <u></u>	17 INFORMANT Address <u>LUDELL MARSHALL PASADENA MD</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Burns - Total</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>1</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Flame from candle</u>			
20c TIME OF INJURY Hour <u>5</u> a.m. <u>PM</u> <u>5/25</u> 19 <u>66</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>Home</u>	20f (City or town) <u>M.D. CO. MD</u>	(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. Linhart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>E. Linhart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			Address (Street, city, town, or county) <u>5/23/66</u>		
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5/25/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	23d LOCATION (City or town) <u>MAGNETY MD</u>	(County) (State)	
24 FUNERAL DIRECTOR <u>Mansur P. Hym</u> ADDRESS <u>638 N. Gilman St</u>			25a REC'D BY REGISTRAR <u>MAY 26 1966</u>	25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



CERTIFICATE OF DEATH

06375

06375

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN Tb 28 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills d. STREET ADDRESS Rt. 1 Box 420 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isaac Middle (NMN) Last MANN		4. DATE OF DEATH Month May Day 4 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1891
9. AGE (In years last birthday) 74 yrs		10. BIRTHPLACE (County & State, or foreign country) North Carolina	11. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. lumberman		10b. KIND OF BUSINESS OR INDUSTRY sawmill	
13. FATHER'S NAME Jeff Mann		14. MOTHER'S MAIDEN NAME Mandy Reese	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 406-12-9360	
17. INFORMANT Mrs. Muli Mann-wife, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO (b) Endotoxins (Gram negative septicemia) DUE TO (c) Decubitus ulcer of sacral area		INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cancer of Lung		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (or another person) attended the deceased from 22 OCT , 19 65 , to 4 MAY , 19 66 , that (I) (or another person) saw the deceased alive on 4 MAY , 19 66 , and that death occurred at 5:25 a.m. from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED 4 MAY 66	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.		22d. ADDRESS South River Med. Ctr., Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/7/66	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis Md.
24. FUNERAL DIRECTOR Hopping Funeral Home - Annapolis, Md.		25a. REC'D BY REGISTRAR MAY 6 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY A.A.CO		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MD b COUNTY H.A.C.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JACOBSON - H.A.CO.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JACOBSON -	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - NORTH PRINCEDEL - HOSP. TAL.		e STREET ADDRESS	
3 NAME OF DECEASED (Type or print) VIRGINIA ELLEN MARSHALL		4 DATE OF DEATH Month 5 Day 23 Year 1966	
5 SEX F	6 COLOR OR RACE N	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-2-1951
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) STUDENT		10b KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	9. AGE (in years last birthday) yrs 14
11 BIRTHPLACE (State or foreign country) A.A.CO MD		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MACKIE MARSHALL		14. MOTHER'S MAIDEN NAME LUDELLER MORMON	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO ---	
17 INFORMANT LUDELLER MARSHALL		Address PASADENA MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BURNS - TOTAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ---	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Home Fire - Total	
20c TIME OF INJURY Month Day Year Hour a.m. 5/23 1966 P.M.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Home
20f (City or town) (County) (State) A.A.CO MD			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE [Signature]		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. Linhardt		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) ---	
22. DATE SIGNED 5/23/66			
23a BURIAL (CREMATION, REMOVAL) (Specify) Burial	23b DATE THEREOF 5/25/66	23c NAME OF CEMETERY OR CREMATORY Mt Zion	23d LOCATION (City or town) (County) (State) MAGOTHY MD
24 FUNERAL DIRECTOR Marshall D. Hays		ADDRESS 638 N. Gilmor St	
25a REC'D BY REGISTRAR MAY 26 1966		25b REGISTRAR'S SIGNATURE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06380

06377

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>BALTIMORE</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNVILLE</u>		c LENGTH OF STAY IN 1b <u>BALTIMORE</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CROWNVILLE STATE HOSPITAL</u>		e STREET ADDRESS <u>3922 KENYON AV.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>M.</u> Last <u>MARTIN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/18/88</u>
9 AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	IF UNDER 24 HRS Hours <u>78</u> Min. <u>78</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>HUDAK</u>	
14 MOTHER'S MAIDEN NAME <u>ANNA Velenovsky</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>	
16 SOCIAL SECURITY NO. <u>-</u>		17 INFORMANT Address <u>James Martin, son, above</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4221</u> DUE TO (b) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>		20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	
20f (City or town) (County) (State) <u>-</u>		20g (City or town) (County) (State) <u>-</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/11/65</u> , 19 <u>65</u> , to <u>5/18/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/18/66</u> , 19 <u>66</u> , and that death occurred at <u>6:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Hollis Tennarine</u>		22b. DATE SIGNED <u>5/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOLLIS TENNARINE</u>		22d. ADDRESS <u>CROWNVILLE STATE HOSPITAL</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/21/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24 FUNERAL DIRECTOR <u>Schimmunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>		25a. REC'D BY REGISTRAR <u>MAY 20 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06387

CERTIFICATE OF DEATH

06378

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adams</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A. A. E. Low Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Box 5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John McDaniel</u>		4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-18</u> 9. AGE (In years last birthday) <u>87</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>General farming</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry McDaniel</u> 14. MOTHER'S MAIDEN NAME <u>Nancy Richert</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> 16. SOCIAL SECURITY NO <u>None</u> 17. INFORMANT <u>Mr. Lora McDaniel</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>SENILITY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>15 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>5-15-66</u> , that (I) (we) last saw the deceased alive on <u>5-14-1966</u> , and that death occurred at <u>6:08 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Lanford Jr. MD</u> 22c. PHYSICIAN'S NAME (Type) <u>ARTHUR LANFORD JR</u>		22b. DATE SIGNED <u>5-15-66</u> 22d. ADDRESS <u>2934 MOUNTAIN RD PASADENA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 23b. DATE THEREOF <u>5-17-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> 23d. LOCATION (City or town or county) (State) <u>Baltimore MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Benning</u>		25a. REC'D BY REGISTRAR <u>MAY 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C6382

CERTIFICATE OF DEATH

07911

1 PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6 mos. 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 4519 Spring Ave.	
3 NAME OF DECEASED (Type or print) #28338		First Charles		Middle McKnight	
Last McKnight		4. DATE OF DEATH		Month 5 Day 25 Year 19 66	
5 SEX Male		6 COLOR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH Aug. 17, 1949		9. AGE (In years last birthday) 16 yrs		IF UNDER 1 YEAR Months 5 Days 25	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Eva May Brooks				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16 SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperventilation Syndrome Associated with DUE TO Emotional Disturbance (b) Mental Deficiency (c) Lifetime					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 5/25		20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/4	
20f (City or town) Brooklyn		20g (County) Brooklyn		20h (State) MD	
21. I certify that (I) (this hospital) attended the deceased from 11/4 , 1964 to 5/25 , 1966 that (I) (we) last saw the deceased alive on 5/25 , 1966 , and that death occurred at 5:15 AM , from causes and on the date stated above.					
22a SIGNATURE L. Benedict, M. D.		22b. DATE SIGNED 5/25/66		22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.	
22d. ADDRESS Crownsville State Hospital, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b DATE THEREOF 5-31-66		23c NAME OF CEMETERY OR CREMATORY McCahay Cent		23d LOCATION (City or Town) Brooklyn	
23e (County) Brooklyn		23f (State) MD		24 FUNERAL DIRECTOR Choy G. Wilson 1011 Brantley Ave	
25a. REC'D BY REGISTRAR DATE JUN 7 1966		25b REGISTRAR'S SIGNATURE Charles J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

C6383

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C6379

1 PLACE OF DEATH a. COUNTY A.A.CO. MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MO b. COUNTY AACO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - NORTH ARUNDEL HOSP.				e. STREET ADDRESS 112 BONNIEVIEW RD.			
3 NAME OF DECEASED (Type or print) First Dewey Middle McLamb Last McLamb				4 DATE OF DEATH Month 5 Day 3 Year 1966			
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAR 23 - 33	9 AGE (In years last birthday) 33 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Inspector			10b. KIND OF BUSINESS OR INDUSTRY WATER ELEC.		11 BIRTHPLACE (State or foreign country) M.C.		12 CITIZEN OF WHAT COUNTRY?
3 FATHER'S NAME HESTER				14 MOTHER'S MAIDEN NAME Temple			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes		6 SOCIAL SECURITY NO 460-50-9196		17 INFORMANT Family - NAME			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Suppurative Vascular Disease, Atherosclerosis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH Instant
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 9		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. L. H. H. H. H.				22. DATE SIGNED 5-3-66			
EXAMINER'S NAME (Type) E. L. H. H. H.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/6/66		23c. NAME OF CEMETERY OR CREMATORY BALTO. MET.		23d. LOCATION (City or Town) (County) (State) BALTO.	
24. FUNERAL DIRECTOR Mr. Kelly - 237 Patapsco Ave.				25a. REC'D BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE John Charles Judge	

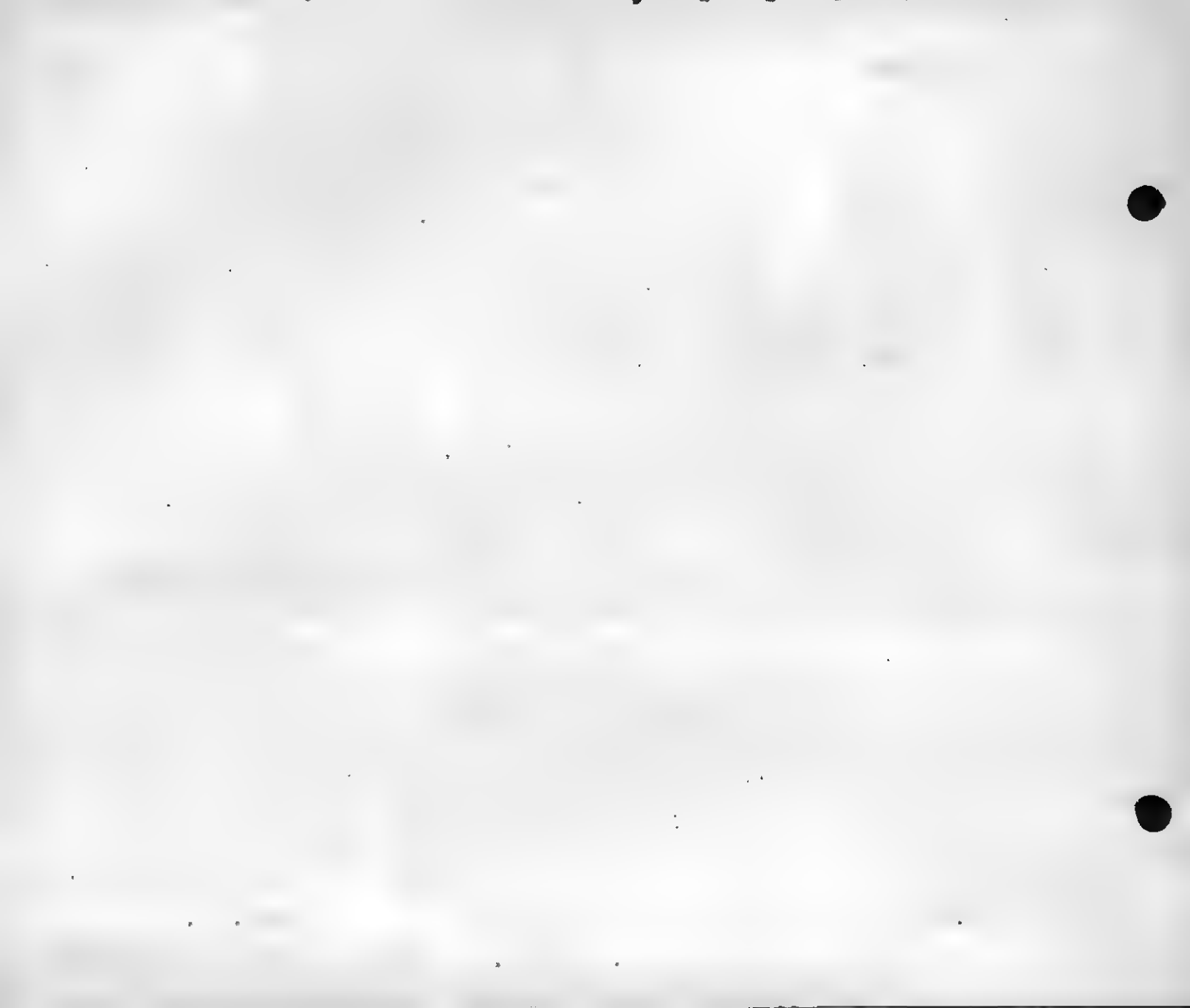
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u> d. STREET ADDRESS <u>Rt. 1 Box 550</u>				
3. NAME OF DECEASED (Type or print) First <u>Maetra</u> Middle <u>D.</u> Last <u>Mc Myne</u>					4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-7-13</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unknown Davis</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Pugh</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nile G. Mc Myne</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rectum & metastasis</u> 154X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1966</u> to <u>May 12, 1966</u>, that (I) (we) last saw the deceased alive on <u>May 12</u> 1966, and that death occurred at <u>5 PM</u>, from the causes and on the date stated above.									
22a. SIGNATURE <u>E. Tulentino</u>					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>E. TULENTINO</u>		
22d. ADDRESS <u>201 Baltimore - Annapolis Rd.</u>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>5 16 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>		
24. FUNERAL DIRECTOR <u>Mc Cully</u>					ADDRESS <u>130 E. Fort Ave.</u>		25a. REC'D BY REGISTRAR <u>MAY 16 1966</u>		
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



FOR STATE
HEALTH DEPT.

00385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06381

1 PLACE OF DEATH a. COUNTY <u>HA CO.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>HA CO</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Severna Park</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North. DEUNDEL - Hosp.</u>				d STREET ADDRESS <u>433 - BROOKS - DRIVE -</u>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>DONALD T McQUOID</u>				4 DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1966</u>			
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>7-21-1904</u>	
9 AGE (In years last birthday) <u>61</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Safety Engineer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Civil Service</u>		11 BIRTHPLACE (State or foreign country) <u>Minneapolis, Minnesota</u>	
12 CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>				13 FATHER'S NAME <u>William McQuoid</u>			
14 MOTHER'S MARDEN NAME <u>Josephine Trobridge</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>			
16 SOCIAL SECURITY NO <u>4-05-24-0530</u>				17 INFORMANT <u>Mrs. Don M. Reynolds (daughter)</u>			
18 ADDRESS <u>87 Luna Lane Round Bay Severna Park, Md.</u>				19 INTERVAL BETWEEN ONSET AND DEATH <u>one hr.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple myeloma.</u> 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident on I-95</u>			
20c TIME OF INJURY Month Day Year <u>7 5/24 1966</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Severna Park 3</u>	
20f (City or town) (County) (State) <u>Elkton MD</u>				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <u>5/24/66</u>				23a LOCATION (City or Town) (County) (State) <u>Davidsonville, A.A. Co., Md.</u>			
23b DATE THEREOF <u>May 27, 1966</u>				23c NAME OF CEMETERY OR CREMATORY <u>All Hallows Chapel Cem.</u>			
23d ADDRESS <u>Singleton Funeral Home, Elkton, Maryland</u>				24. FUNERAL DIRECTOR <u>R. V. Singleton</u>			
25a REC'D BY REGISTRAR <u>May 27 1966</u>				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
063886
CERTIFICATE OF DEATH
063882

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 16 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS Qtrs #3 U.S. NAVAL HOSPITAL e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amy First Florence Middle Miller Last		4. DATE OF DEATH May Month 2 Day 1966 Year	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 May 1889	
9. AGE (In years last birthday) 76 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Toronto, Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Walter Williams		14. MOTHER'S MAIDEN NAME Emma Sarah Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 176 28 7352	
17. INFORMANT Capt. M.K. Steele, MC, USN Address QTRS 3 USNH Anna. Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] (Son-in-law) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION DUE TO (b) CARCINOMA OF COLON METASTATIC DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 30 Days 2 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1 April , 19 66 , to 2 May , 19 66 , that (I) did last saw the deceased alive on 2 May , 19 66 , and that death occurred at 2:40 PM from the causes and on the date stated above.			
22a. SIGNATURE Howard E. Shute		22b. DATE SIGNED 2 May 1966	
22c. PHYSICIAN'S NAME (Type) H.E. SHUTE, LCDR, MC, USN		22d. ADDRESS U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 6 1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City, town or county) (State) Druid Hill, Prince Georges	
24. FUNERAL DIRECTOR Thomas A. HARDESTY		25a. REC'D BY REGISTRAR MAY 4 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME-66
GM 1/66

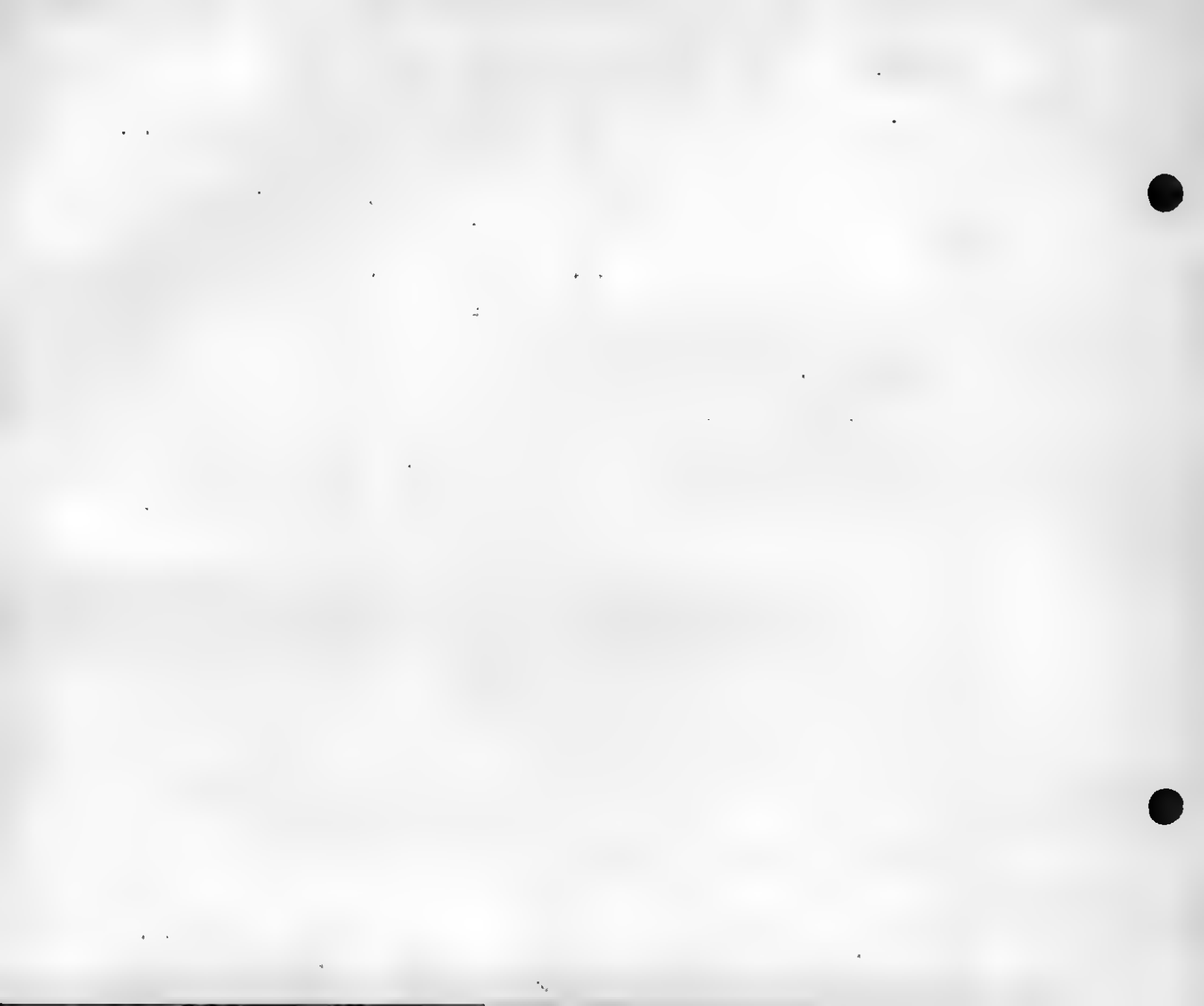
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

66387

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66383

1 PLACE OF DEATH a COUNTY <u>A.A. Co</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>A.A.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS-ROADS.</u>		c LENGTH OF STAY IN 1b <u>Annopolis-</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.N.-ARNE-ARUNDEL-GENERAL</u>		e STREET ADDRESS <u>Rt 5 Box 293 A, St. Margaret</u>	
3 NAME OF DECEASED (Type or print) First <u>DANIEL L.</u> Middle <u>T.W.</u> Last <u>MORGAN, Jr.</u>		4 DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/2/26</u>
9 AGE (In years last birthday) <u>40</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (Sup.)</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>	
11 BIRTHPLACE (State or foreign country) <u>Clifton Heights, Pa.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Daniel T.W. Morgan, Sr.</u>		14 MOTHER'S MAIDEN NAME <u>Beatrice Hewitt</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>II</u>		16 SOC. A. SECURITY NO. <u>218-12-9539</u>	
17 INFORMANT <u>Mrs. Gilma B. Morgan-wife</u>		Address <u>same as #2 above</u>	
18 CAUSE OF DEATH (Enter on y one cause per line or (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>0</u> min <u>0</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Hopping</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Hopping</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>5/28/66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b DATE THEREOF <u>5/31/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	23d LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24a FUNERAL DIRECTOR <u>Beverly E. Hopping</u>		24b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Hopping Funeral Home <u>Annapolis, MD</u>		25a RECD BY REGISTRAR <u>JUN 1 1966</u>	



06388

CERTIFICATE OF DEATH

06384

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 16 4 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-4, Box-341	
3 NAME OF DECEASED (Type or print) Betty Moulden		4. DATE OF DEATH Month May Day 27 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1966
9. AGE (In years lost birthday) yrs 4		10. IF UNDER 1 YEAR Months 4 Days 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ernest Calvin Downs		14. MOTHER'S MAIDEN NAME Janice Lucille Moulden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Etta Butler Rt-Edgewater		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity - One pound plus DUE TO (b) 1165 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 1165 DUE TO			INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from May 26, 19 66 , to May 27, 19 66 , that (I) (we) last saw the deceased alive on May 27, 19 66 , and that death occurred at 2:20 AM M, from causes on and on the date stated above.			
22a. SIGNATURE Philip Briscoe		22b. DATE SIGNED 5/27/66	
22c. PHYSICIAN'S NAME (Type) Philip Briscoe, M.D.		22d. ADDRESS 201 Forbes St., Annapolis, Md.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE THEREOF May 5-29-66	23c. NAME OF CEMETERY OR CREMATORY Hoped Memorial	23d. LOCATION (City or Town) (County) (State) Edgewater Md.
24. FUNERAL DIRECTOR William Reese		25a. REC'D BY REGISTRAR JUN 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06389					06385						
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joyce Lane</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold Md</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Arnold</u>					d. STREET ADDRESS <u>Joyce Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LYDA JANE Munroe</u>					4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>66</u> 19						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 29, 1883</u>		9. AGE (In years last birthday) <u>83</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Arnold Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Cyrus N. Joyce</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs Gilbert H. Moore #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C. V. D.</u> DUE TO (c) <u>Gender</u>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>5-23</u> 19 <u>66</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert R. HAHN</u>					22b. DATE SIGNED <u>5-29-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>6-1-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLVD</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>		
24. FUNERAL DIRECTOR <u>John M. Lytle & Sons Annapolis, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JUN 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

TO HOSPITAL
death. Page 4
TO FUNERAL
director, page 3
be filed with the

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

NOTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06380

06386

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A. Co.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
c. LENGTH OF STAY IN TB				d. STREET ADDRESS <u>Wileanor Estates</u>			
e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNAPOLIS Nursing HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY E. MURPHY</u>				4. DATE OF DEATH Month Day Year <u>5 22 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-25-1876</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Patrick Rigney</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE KINSELLA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>JOHN J. MURPHY</u>			
17. INFORMANT <u>Wileanor Estates</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral failure</u> DUE TO (b) <u>Cerebral artery disease</u> DUE TO (c) <u>Cerebral artery disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hidden intra abdominal malignancy</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 1966, to <u>May 22</u> 1966, that (I) (we) last saw the deceased alive on <u>May 22</u> 1966, and that death occurred at <u>3</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>George O'Brien</u> M.D.				22b. DATE SIGNED <u>5/23/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>George O'Brien</u>				22d. ADDRESS <u>121 Calthea St, Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5-24-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		23d. LOCATION (City, town or county) (State) <u>Washington N.J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Tylus</u>				25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																							
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Green Burnie</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Odenton</u> d. STREET ADDRESS <u>1379 Becknel Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																		
3. NAME OF DECEASED (Type or print) <u>EDWIN R. NUTTER</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1966</u>		5. SEX <u>MALE</u>			6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-30-76</u>		9. AGE (In years last birthday) <u>89</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																						
Months	Days																						
	Hours																						
	Min.																						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>B and O RR</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>			12. CITIZEN OF WHAT COUNTRY?													
13. FATHER'S NAME <u>Nutter</u>						14. MOTHER'S MAIDEN NAME <u>?</u>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>705-05-6719</u>			17. INFORMANT <u>Mrs. M. Louise Nutter</u> same address as above <div style="text-align: right;">Address</div>																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>12-24 hours</u> <u>years</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION														20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
														20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
														21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>66</u> , to <u>5/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>66</u> , and that death occurred at <u>2-9</u> M. , from the causes and on the date stated above.				22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>5/20/66</u>			
														22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/24/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Carroll County, Md.</u>																	
24. FUNERAL DIRECTOR <u>Wm. J. Lickens & Sons</u>				25a. REC'D BY REGISTRAR <u>Charles J. [Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>																	
25c. ADDRESS <u>Baltimore, Md.</u>				25d. DATE <u>MAY 23 1966</u>																			

06392

CERTIFICATE OF DEATH

06388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 13 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Fair Hill Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First George Middle Harold Last O'BRIEN		4 DATE OF DEATH Month May Day 8 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 31, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret- bellhop		10b. KIND OF BUSINESS OR INDUSTRY hotel	9. AGE (In years last birthday) yrs 63
11 BIRTHPLACE (County & State, or foreign country) Bethlehem Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George O'Brien		14. MOTHER'S MAIDEN NAME Connelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 171-09-5782a	17. INFORMANT Mrs. Elizabeth O'Brien - same as #2 above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO (b) Cancer of colon DUE TO (c) 9 months			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 2040g , 19 65 , to May 8 , 19 66 that (I) (we) last saw the deceased alive on May 8 , 19 66 , and that death occurred at 6:00 AM from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED 9 May 66	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.		22d. ADDRESS South RivMedCent., Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/11/66	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis, Md.
24. FUNERAL DIRECTOR Hopping Funeral Home - Annapolis, Md.		25a. REC'D BY REGISTRAR MAY 12 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06389

CERTIFICATE OF DEATH

Item to fill in 5/23/66 mh

06389

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanadale - Glen Burnie</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		
c. LENGTH OF STAY in 1b <u>6 yr.</u>			d. STREET ADDRESS <u>106 Linden Ave</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>106 Linden Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leslie Willard Orrison</u>			4. DATE OF DEATH Month Day Year <u>May 21 1966</u>		
5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>5/22/90</u>		
9. AGE (in years last birthday) <u>75</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours M.n. <u>75</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher BRDR.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RR - Retired</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Libertyville</u>			12. CITIZEN OF WHAT COUNTRY? <u>same</u>		
13. FATHER'S NAME <u>Stephen Orrison</u>			14. MOTHER'S MAIDEN NAME <u>Mary Vertz</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wear or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>405-10-4169</u>		
17. INFORMANT <u>Bertha Orrison</u>			Address <u>1214 19th St</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arterio-Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>8-10 yr.</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>May 16</u> , 19 <u>66</u> , to <u>May 21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 21</u> , 19 <u>66</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Chas. L. Ball</u>			22b. DATE <u>5/21/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>McCully Funeral Home</u>			22d. ADDRESS <u>1214 19th St</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5-24-66</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Fubuck, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>			25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 1m G377 37777

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C6394

Item 7 Film 4377- 5/31/66 mh

C6390

1. PLACE OF DEATH
a. COUNTY Anne Arundel Co MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md
c. LENGTH OF STAY IN 1b 22 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Flora KAVOR Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 47 Calvert Street
e. 15 RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) James - SEIMON - Owens
First Middle Last
4. DATE OF DEATH 5 18 1966
Month Day Year

5. SEX Male Negro
6. COLOR OR RACE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 4-17-1890
9. AGE (In years last birthday) 76 yrs.
10. IF UNDER 1 YEAR Months Days
11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b. KIND OF BUSINESS OR INDUSTRY Calvert Co. Md.
11. BIRTHPLACE (County & State, or foreign country) U.S.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME FLOYD OWENS
14. MOTHER'S MAIDEN NAME Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
16. SOCIAL SECURITY NO. 212-16-5373
17. INFORMANT Catherine Tignor Address Glen Burnie, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage
7201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) C.V.D. (Cardio-vascular disease)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH Spontaneous
unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr. 27 1966 to May 18 1966; that (I) (we) last saw the deceased alive on May 18 1966, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE Richard H. Hunt M.D.
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Richard H Hunt
22d. ADDRESS 100 Cherry Lane, Glen Burnie, Md.
22e. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

23a. BURIAL, CREMATION REMOVAL, (Specify) BURIAL
23b. DATE THEREOF MAY 21-66
23c. NAME OF CEMETERY OR CREMATORY Brewer Hill
23d. LOCATION (City, town or county) (State) Annapolis - Md.

24. FUNERAL DIRECTOR'S SIGNATURE Charles Hicks III Address 4500 West
25a. REC'D BY REGISTRAR MAY 24 1966
25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 1b Film G377 6/10/66 mh

06395

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06391

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rd 1 Patapsco Park</u>		c. LENGTH OF STAY IN lb <u>Peloposo - Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>145 Sherbrook Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>Palmer</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Irene Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Irene Palmer</u>		Address <u>145 Sherbrook Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Chronic diseases</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from _____ Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Hubbard</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Hubbard</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>8/18/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/23/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary</u>	23d. LOCATION (City or Town) (County) (State) <u>A.A. Co. MD</u>
24. FUNERAL DIRECTOR <u>J. L. Brown</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 27 1966</u>	
ADDRESS <u>108 W. Montgomery St.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film 3377 5/23/66 mh

06396

CERTIFICATE OF DEATH

06392

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an: Residence before admission) a STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brownsville		c. LENGTH OF STAY IN tb 7 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 770 W. Saratoga St.	
3 NAME OF DECEASED (Type or print) Sarah Parker First Middle Last		4 DATE OF DEATH Month Day Year 5 18 1966	
5. SEX Female	6. COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/12/1893
9. AGE (In years last birthday) yrs 72		IF UNDER 1 YEAR Months Days 18 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State or foreign country) Prince George Co. Md. USA		12. CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Henry Freeman		14 MOTHER'S MAIDEN NAME Annie Queen	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Senility DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration - Inanition			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/6/ , 19 65 , to 5/18/ , 19 66 that (I) (we) last saw the deceased alive on 5/18/ 19 66 , and that death occurred at 10:05 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Charles Judge</i>		22b. DATE SIGNED 5/18/66	
22c. PHYSICIAN'S NAME (Type) Lionel Henry Kapp, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 23, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR Williams Funeral Home 3197 S. Howard St.		25a. REC'D BY REGISTRAR MAY 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

C6397

CERTIFICATE OF DEATH

C6393

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 17 days		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits: write RURAL and give nearest town) RURAL - Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital: give street address) Anne Arundel General Hospital				d. STREET ADDRESS 3 E. Lake Drive Bay Ridge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Freeman R. PAULSON		4 DATE OF DEATH Month May Day 30 Year 19 66		5 SEX Male		6 COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1893		9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS: Hours 0 Min 0	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10b. KIND OF BUSINESS OR INDUSTRY TAXES		11. BIRTHPLACE (County & State, or foreign country) Forest City, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Paul K. Paulson				14. MOTHER'S MAIDEN NAME MARIE HAHVORSEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-44-4245		17. INFORMANT ELHA H. PAULSON #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Adenocarcinoma of Stomach DUE TO (c) with metastasis to lung & abdomen						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (as hospital) attended the deceased from 5-16-66 , to May 30 , 19 66 , that (I) (not) saw the deceased alive on May 30 , 19 66 , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 5-31-66		22c. PHYSICIAN'S NAME (Type) FM SHIPLEY		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-2-66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) BLADENSBURG MD.	
24. FUNERAL DIRECTOR John M. Taylor & Sons Chapersols, Md.		25a. REC'D BY REGISTRAR JUN 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

1944

1945

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06398

06394

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 5 Box 112</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>R. 5 - Box 112</u>	
3. NAME OF DECEASED (Type or print) <u>Violet Arlene Pearson</u> First Middle Last 4. DATE OF DEATH <u>5-16-1966</u> Month Day Year		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-19-1945</u> 9. AGE (In years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William H. Pearson</u> 14. MOTHER'S MAIDEN NAME <u>Alma H. Tucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>Alma H. Pearson</u> 17. INFORMANT <u>Alma H. Pearson</u> Address <u>Annapolis</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>5 days</u> (a), stating the underlying cause last. (c) <u>5 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>11-5-58</u> to <u>5-16-66</u> , that (I) (we) last saw the deceased alive on <u>5-15-66</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>T. Allen M.D.</u> 22b. DATE SIGNED <u>5-16-66</u> 22c. PHYSICIAN'S NAME (Type) <u>T. ALLEN, M.D.</u> 22d. ADDRESS <u>62 Cathedral St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5-19-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u> 23d. LOCATION (City, town or county) (State) <u>St. Margaret's</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>MAY 17 1966</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Annapolis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-66

(M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

066399

066395

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 2 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Marshall		First (none) Middle POWELL Last		4. DATE OF DEATH Month May Day 5 Year 19 66			
5 SEX Male	6 COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1904		9 AGE (In years last birthday) 61 yrs	10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11 BIRTHPLACE (County & State, or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MARDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-12-9131		17. INFORMANT Charles Edwards Davidsonville Address			
18 CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilat. Hyaline Pneumonia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ch. Bronchectasis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from May 3, 1966 , to May 5, 1966 , that (I) (we) lost the deceased alive on May 4, 1966 , and that death occurred at 12:40 AM from causes on and on the date stated above.							
22a. SIGNATURE Maurice Klawans		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/5/66			
22c. PHYSICIAN'S NAME (Type) Maurice Klawans, M.D.		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5.8.1966		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City or Town) (County) (State) Annapolis Md	
24. FUNERAL DIRECTOR William Reese		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

06400

CERTIFICATE OF DEATH

06396

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CROWNSVILLE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1618 LANING AVENUE</u>	
3. NAME OF DECEASED (Type or print) <u>CASPER</u> Middle <u>RABENAU</u> Last		4. DATE OF DEATH Month <u>MAY</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/1882</u>
9. AGE (in years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>66</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN R. RABENAU</u>		14. MOTHER'S MAIDEN NAME <u>MARY DOERING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Mr. Milton Price, Hydes, Md.</u>		Address <u>-</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO <u>493X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO <u>-</u> (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DEHYDRATION AND MALNUTRITION</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>-</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State) <u>-</u>
21. I certify that (I) (this hospital) attended the deceased from <u>6/13/64</u> , 19 <u>64</u> , to <u>3/14/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/14/66</u> , 19 <u>66</u> , and that death occurred at <u>7:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Hollis Seunarine, M.D.</u>		22b. DATE SIGNED <u>5/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOLLIS SEUNARINE</u>		22d. ADDRESS <u>CROWNSVILLE STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/17/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>LEONARD J. RUCK, INC., BALTO., MD. 21214</u>		25a. REC'D BY REGISTRAR <u>DA</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 17-1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then (page 3) remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

06397

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Luthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>212 Mountain Rd.</u>		d. STREET ADDRESS <u>1245 Sergeant St</u>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>A.</u> Last <u>Rayner</u>	DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1966</u>		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-17-89</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Adam Ludwig</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>John Rayner - Same as (b+d)</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic Heart Disease</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u> <u>2 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> to <u>5/18</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5/15</u> , 19 <u>66</u> , and that death occurred at <u>8:00</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John P. Urlock Jr.</u> M.D.		22b. DATE SIGNED <u>5/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCK JR</u>		22d. ADDRESS <u>1227 Wash. Blvd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son - Inc</u> ADDRESS <u>23 Collins St</u>		25 MAY 19 1966 DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
66402					66399						
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> Pa. b. COUNTY <u>Anne Arundel</u> Del.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>1 1/2 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> Upper Marlboro			d. STREET ADDRESS <u>630 Ridge Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Augusta</u> Last <u>REMENTER</u>			4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1966</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 February 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George Briggs</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Niblock</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>198-12-3802</u>		17. INFORMANT (Daughter) <u>Mrs. Patricia R. Saroch</u>			Address <u>30 Upstar Road Annapolis Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Athero Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (X) (this hospital) attended the deceased from <u>9 May</u> , 19 <u>66</u> to <u>21 May</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>21 May</u> , 19 <u>66</u> and that death occurred at <u>8:15 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert L. Shirley</u> LCDR (MC) USNR M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>21 May 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Robert L. Shirley, LCDR MC USNR</u>					22d. ADDRESS <u>U.S. Naval Hospital, Annapolis Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-24-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hebington Cert.</u>		23d. LOCATION (City, town or county) (State) <u>Drexel Hill Pa.</u>					
24. FUNERAL DIRECTOR <u>John M. Taylor</u>					ADDRESS <u>1000 E. Annapolis Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06403

06400

1. PLACE OF DEATH e. COUNTY <u>AA Co</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>	
c. LENGTH OF STAY IN 1b <u>15 yrs</u>		d. STREET ADDRESS <u>MASONS BEACH</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jesse Noble Rice</u>		4. DATE OF DEATH Month Day Year <u>May 17 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 7, 1886</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNMENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baileys Crossroad, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN W. Rice</u>		14. MOTHER'S MAIDEN NAME <u>MARY Ellen ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes 1906-1908</u>		16. SOCIAL SECURITY NO. <u>578-09-6866</u>	
17. INFORMANT <u>Ida May Rice</u>		Address <u>Deale, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CVA</u>			
Conditions, if any, which gave rise to immediate cause (b) <u>Atherosclerotic CVA</u>			
(c) <u>Arteriosclerotic CVA</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4 May 1966</u> to <u>17 May 66</u> , that (I) (we) last saw the deceased alive on <u>14 May 1966</u> , and that death occurred at <u>4 M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. B. Parker MD</u>		22b. DATE SIGNED <u>17 May 66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>May 20/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, VA</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>T. H. Hester, Gaesville, Md</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

066404

CERTIFICATE OF DEATH

066401

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FERNDALE		c. LENGTH OF STAY IN 1b FERNDALE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 403 MELROSE AVENUE		d. STREET ADDRESS 403 MELROSE AVENUE	
3 NAME OF DECEASED (Type or print) First Middle Last ETHEL M. RULE		4 DATE OF DEATH Month Day Year MAY 13 1966	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB. 1, 1890
9 AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOMEMAKER	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME WILLIAM RHODES	
14. MOTHER'S MAIDEN NAME ELLA RANKIN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO. ---		17. INFORMANT Address MRS. K. R. KUHN, 50 GLENDALE AVE. 2106	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Uremia 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Diabetes Mellitus DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 5-13-66 to 5-13-66 , that (I) (we) last saw the deceased alive on 5-13-66 , and that death occurred at 7:30 PM , from causes and on the date stated above.	
22a. SIGNATURE Ignas Saulynas		22b. DATE SIGNED 5-13-1966	
22c. PHYSICIAN'S NAME (Type) IGNAS SAULYNAS		22d. ADDRESS 319-A OLD ANNAPOLIS ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-17-66	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE 25, MARYLAND	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE		25a. REC'D BY REGISTRAR MAY 17 1966	
25b. REGISTRAR'S SIGNATURE Howard H. Hubbard			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 through 5 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY A.A. CO. MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE VA. b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapoles		c LENGTH OF STAY IN 1b Falls Church	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL - GENERAL		e STREET ADDRESS 6907 Jefferson Pk.	
3 NAME OF DECEASED (Type or print) First BARBARA Middle J. Last Ryon		4 DATE OF DEATH Month 5 Day 28 Year 1966	
5 SEX Female	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 7, 1943
9 AGE (In years last birthday) 23 yrs		10 IF UNDER 1 YEAR Months 2 Days 28 Hours 19 Min 66	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary		10b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11 BIRTHPLACE (State or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Paul Leo Ryon		14 MOTHER'S MAIDEN NAME Mary Schenk	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 233-66-7330	
17 INFORMANT Paul Ryon (father) 6907 Jefferson Ave.		Address Falls Church, Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) multiple injuries 8-20-66 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1-1/2 hrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Auto accident - Route 2 -	
20c TIME OF INJURY Month Day Year Had a m. 5/28 1966 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Highway		20f (City or town) (County) (State) AA. CO. MD.	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhardt		22. DATE SIGNED 5/28/66	
EXAMINER'S NAME (Type) E. Linhardt		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-31-66	23c NAME OF CEMETERY OR CREMATORY National Memorial Park	23d LOCATION (City or Town) (County) (State) Falls Church, Virginia
24 FUNERAL DIRECTOR W. J. McDonald		25a REC'D BY REGISTRAR JUN 2 1966	
Falls Church Funeral Home 1102 W. Broad St Falls Church, Va.		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

06406

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06403

1 PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb D O A		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. STREET ADDRESS Friendship				f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ODEN		First A.		Middle SANSBURY		Last SANSBURY		4 DATE OF DEATH Month May	
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 11-25-88		9 AGE (In years last birthday) 77 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edwin H. Sansbury	
14. MOTHER'S MAIDEN NAME Emma Webb		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-3280		17. INFORMANT Mrs. Irene Sansbury, Friendship, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: Driver in auto-auto collision					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:30 p.m. 5-13-1966				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Rudiger Breiteneker, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 5-14-66	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16, 1966		23c. NAME OF CEMETERY OR CREMATORY Friendship Chr. Cemetery		23d. LOCATION (City or Town) (County) (State) Friendship, A.A. Md.		24. FUNERAL DIRECTOR Hutchins Funeral Home	
ADDRESS Owings, Maryland				25a. REC'D BY REGISTRAR MAY 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06407		06404	
1. PLACE OF DEATH a. COUNTY Anne Arundel County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b Two Hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum d. STREET ADDRESS 1207 Winterson Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frederick William Schrufer		4. DATE OF DEATH Month Day Year May 3 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27 1913 9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Brewery	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Schrufer		14. MOTHER'S MAIDEN NAME Mrs Streb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. 2		16. SOCIAL SECURITY NO. 218-09-3426	
17. INFORMANT Thelma Schrufer, 1207 Winterson Road, Linthicum, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular disease 4221 DUE TO (b) Chirrosis of liver DUE TO (c) Cerebral-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4-6 mos 2-3 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 1965, to 5/3 1966, that (I) (we) last saw the deceased alive on 5/3 1966, and that death occurred at 12:45 M, from the causes and on the date stated above.			
22a. SIGNATURE Charles L. Ball Jr.		22b. DATE SIGNED 5/3/66	
22c. PHYSICIAN'S NAME (Type) Dr Charles Ball Jr.		22d. ADDRESS 203 West Maple Rd, Linthicum, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 6, 1966	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town or county) (State) Frederick Rd Baltimore Md
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy, Balto 25		25a. REC'D BY REGISTRAR MAY 6 1966	
		25b. REGISTRAR'S SIGNATURE Charles J. J.	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

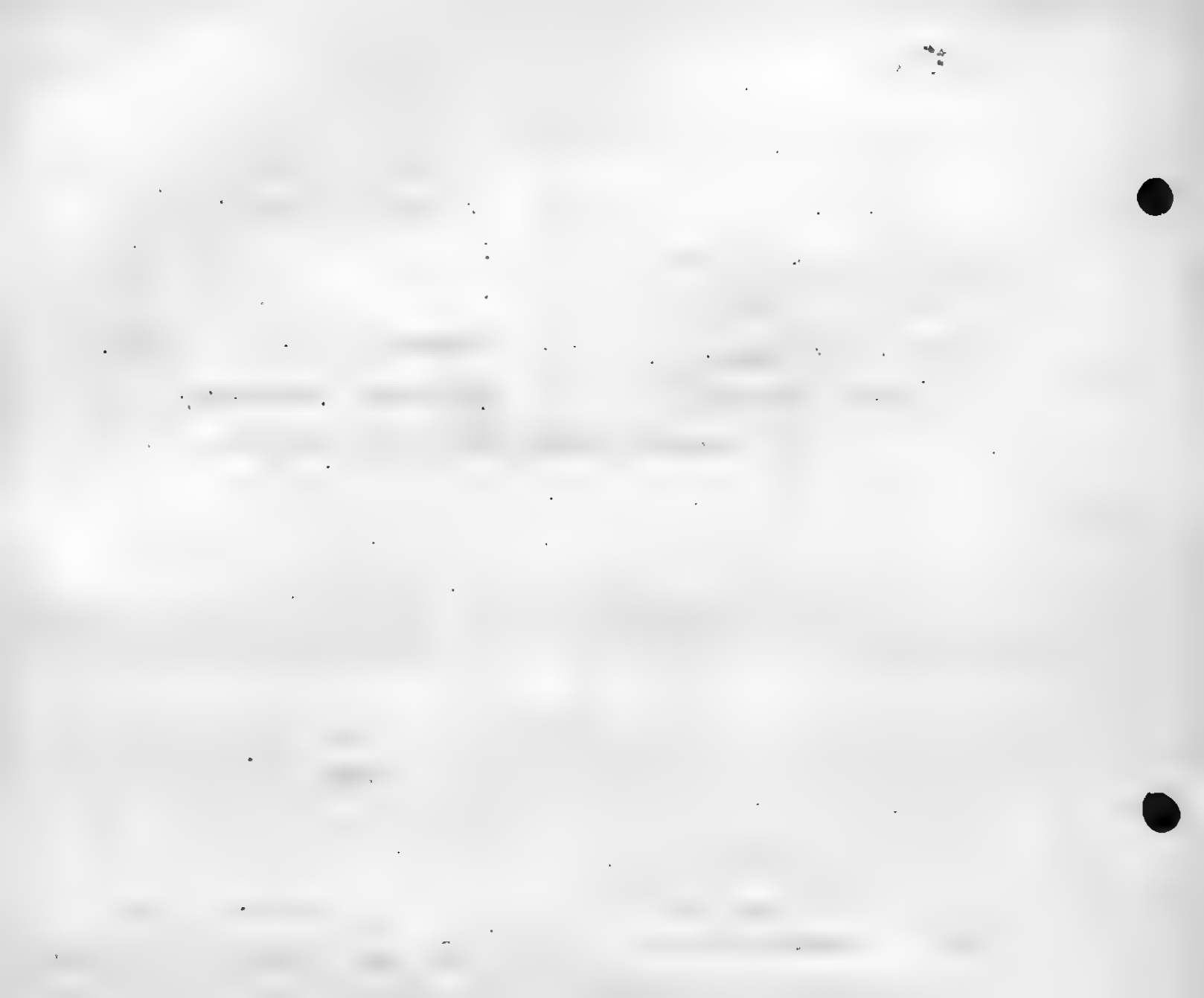
06408

06405

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltzville</u> c. LENGTH OF STAY IN ID <u>21230</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NORTH ARUNDEL HOSP.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>17D.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>122 W. BURNETT ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>August 7 Seabreeze</u>		4. DATE OF DEATH <u>5/21/66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/3/1911</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Repair</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK SEABREEZE</u>		14. MOTHER'S MAIDEN NAME <u>EMMA GEISMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-07-9633</u>	
17. INFORMANT <u>Catherine I. Seabreeze - (wife)</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart failure</u> 416X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart disease +</u> DUE TO (c) <u>Coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 13</u> , 19 <u>54</u> , to <u>May 19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 19</u> , 19 <u>66</u> , and that death occurred at <u>11:10 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>George M'Lean</u>		22b. DATE SIGNED <u>May 23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE M'LEAN</u>		22d. ADDRESS <u>705 Med Arts Bldg</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MD-MAY 25-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLENDAURN Cem.</u>	23d. LOCATION (City, town or county) (State) <u>GLENDAURN, MD.</u>
24. FUNERAL DIRECTOR <u>CURTIS E. EVANS</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1400 S. CHARLES ST. BALTIMORE MD 21230</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06409

06406

1. PLACE OF DEATH a. COUNTY <u>Annapolis</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>68 College Ck. Terrace</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before, address on) a. STATE <u>MD.</u> b. COUNTY <u>Annapolis</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>68 College Ck. Terrace</u>			
3. NAME OF DECEASED (Type or print) <u>Arnie</u>		4. DATE OF DEATH Month <u>5</u> - Day <u>28</u> Year <u>1966</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1886</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>28</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
3. FATHER'S NAME <u>Thomas Wavis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wavis</u>		17. INFORMANT <u>Elizabeth Spencer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>443X</u>		17. ADDRESS <u>68 College Ck. Terrace</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardio Vascular Disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>One Year</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) tended the deceased from <u>May 27, 1966</u> to <u>May 28, 1966</u> that (I) (we) last saw the deceased alive on <u>May 28, 1966</u> , and that death occurred at <u>12:35</u> P.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>R. L. Richardson</u>		22b. DATE SIGNED <u>May 30, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M.D.</u>			
22d. ADDRESS <u>110 Clay St., Annapolis, Maryland</u>		23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial 6-1-1966</u>					
23b. DATE THEREOF <u>6-1-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>		23d. LOCATION (City, town or county) <u>Annapolis MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		24b. ADDRESS <u>Annapolis MD.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>JUN 1 1966</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

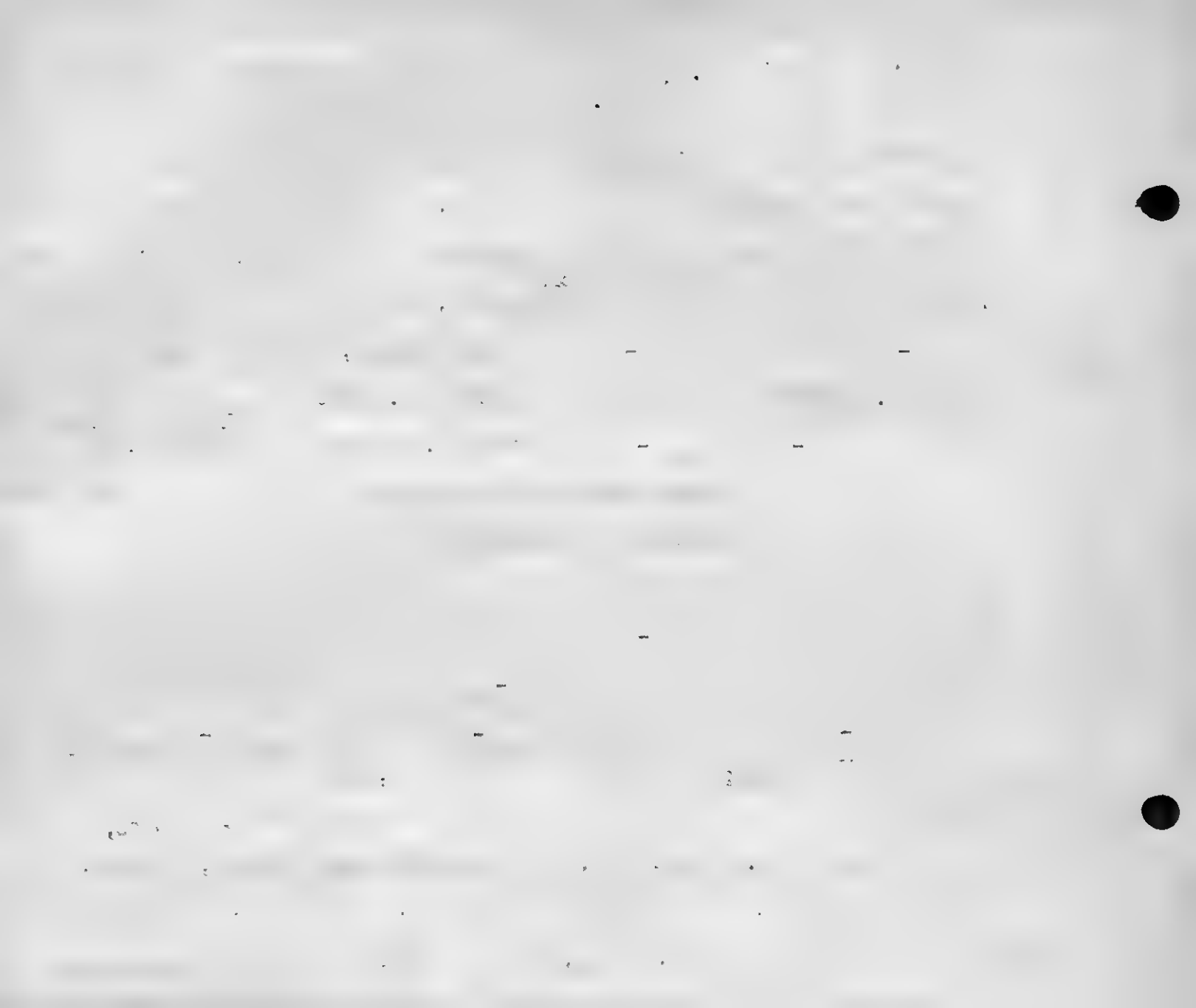
1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 206 N/ Hammonds Ferry Road		d. STREET ADDRESS 206 N/ Hammonds Ferry Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD LUTHER SHIPLEY JR.		4. DATE OF DEATH Month Day Year May 11 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1880
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (ret)		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Luther Shipley		14. MOTHER'S MAIDEN NAME Anne L. Linthicum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Richard H. Shipley- Linthicum, Md.		Address 302 S/ Ft. Meade Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 weeks 8 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1957 to 5-10 1966, that (I) (we) last saw the deceased alive on 5-10 1966, and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE C.R. MacDonald M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C.R. MacDonald		22d. ADDRESS 204 S/ Crain Hwy. Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 14 May 1966	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Singleton Funeral Home/ Glen Burnie, Md.		25a. REC'D BY REGISTRAR MAY 17 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, at the funeral home, within 72 hours after death.

VR AIS (4)
20M 5-63

<div>1</div> <div>06411</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>06408</div>											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G MEADE c. LENGTH OF STAY IN 1b 3 HRS 25 MIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 6601 Woods Pkwy e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) NOT NAMED			First SIMPSON Middle LAST SIMPSON			4. DATE OF DEATH MAY 20 1966			5. SEX MALE		
6. COLOR OR RACE NEG		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 20, 1966		9. AGE (In years last birthday) 3		IF UNDER 1 YEAR Months Days Hours Min. 25		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DOUGLAS R. SIMPSON						14. MOTHER'S MAIDEN NAME FRANCES E. JACKSON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. - 17. INFORMANT DOUGLAS R. SIMPSON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC AND RESPIRATORY ARREST 7 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) IMMATURITY AND PREMATURITY (c)						INTERVAL BETWEEN ONSET AND DEATH 3 HRS 25 MIN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -											
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. - p.m. -				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) - (County) - (State) -			
21. I certify that xxx (this hospital) attended the deceased from MAY 20 1966 to MAY 20 1966 that xx (we) last saw the deceased alive on MAY 20 1966 and that death occurred at 4:10PM from the causes and on the date stated above.											
22a. SIGNATURE Benjamin E. Dunlap M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> MAY 20, 1966			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) BENJAMIN E. DUNLAP, CAPT, MC						22d. ADDRESS KIMBROUGH ARMY HOSPITAL, FT MEADE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF May 24, 1966		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.			23d. LOCATION (City, town or county) Frederick Ave., Baltimore, Md. (State) -			
24 FUNERAL DIRECTOR'S SIGNATURE Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland						25a. REC'D BY REGISTRAR MAY 24 1966			25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 5 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
06412		06409	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY <u>A. A.</u>	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	a. STATE <u>Maryland</u>	b. COUNTY <u>Anne Arundel</u>
c. LENGTH OF STAY IN lb	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>51 Southgate Ave.,</u>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	d. STREET ADDRESS <u>51 Southgate Ave.,</u>
3. NAME OF DECEASED (Type or print) <u>Anne</u>	4. DATE OF DEATH <u>May 29 1966</u>	5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1964</u>	9. AGE (In years last birthday) <u>2</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Alexander L. Slafkosky</u>	14. MOTHER'S MAIDEN NAME <u>Margaret M. Hoff</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>	16. SOC. A. SECURITY NO. <u> </u>	17. INFORMANT <u>Alexander L. Slafkosky-father, same as #2</u>	18. ADDRESS <u> </u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <u>mental retardation - severe</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20d. (City or town, (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from... <u>5/28</u> 19 <u>66</u> , to... <u>5/29</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on... <u>5/28</u> 19 <u>66</u> , and that death occurred at <u>4:15</u> P.M. from the causes and on the date stated above.	22a. SIGNATURE <u>Philip Briscoe</u>	22b. DATE SIGNED <u>5/29 66</u>	22c. PHYSICIAN'S NAME (Type) <u>Dr. Philip Briscoe</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/31/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Annapolis, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hoping Funeral Home - 72 West St., Annapolis, Md.</u>	25. REC'D BY REGISTRAR <u>JUN 1 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

066413

CERTIFICATE OF DEATH

066410

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills	
c. LENGTH OF STAY IN 1b 1 hour		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type of print) First Carl Middle Eric Last SMITH		4. DATE OF DEATH Month May Day 9 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1966
9. AGE (In years last birthday) yrs 1		10. IF UNDER 1 YEAR Months 1 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Edward Smith		14. MOTHER'S MAIDEN NAME Alice Alverta Dorsey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 7625 IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Pneumonia DUE TO (c) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 9, 1966 , to May 9, 1966 , that (I) (see) lost saw the deceased alive on May 9, 1966 , and that death occurred at 4:15 AM M, from causes and on the date stated above.			
22a. SIGNATURE T. H. Johnson, M.D.		22b. DATE SIGNED 5/11/66	
22c. PHYSICIAN'S NAME (Type) T. H. Johnson, M.D.		22d. ADDRESS 20 Dean St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/12/66	23c. NAME OF CEMETERY OR CREMATORY W. of Md.	23d. LOCATION (City or town) (County) (State) Balto. - A.C. Md.
24. FUNERAL DIRECTOR William Reese, Jr. - Annapolis, Md.		25a. REC'D BY REGISTRAR DATE MAY 16 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06414

06411

1. PLACE OF DEATH a. COUNTY <u>ANCO.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VA</u> b. COUNTY <u>Buckingham</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u>		c. LENGTH OF STAY IN 1b <u>2 Months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u># 4 Eleanor Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>Lee</u> Last <u>SNODDY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4 - 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gordon Lee Snoddy</u>		14. MOTHER'S MAIDEN NAME <u>Bryne Knuckles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Edna Chapman</u>		Address <u># 4 Eleanor Avenue Linthicum, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4500 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>5/23/66</u>	
EXAMINER'S NAME (Type) <u>E Linhardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 26, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Methodist Cemetery Arvonia, Virginia</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <u>George J. Gonce</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>4001 Ritchie Hwy, Balto, Md</u>		DATE <u>MAY 25 1966</u>	

FOR STATE
HEALTH DEPT.

06415

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06412

1 PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena A (Sunset Knoll)</u>	
c. LENGTH OF STAY IN 1b <u>2-10-1966</u>		d. STREET ADDRESS <u>RL 5-Box 88</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.M. North Avenue General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>SARA</u> Middle <u>Steidinger</u> Last <u>Steidinger</u>		4 DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1966</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan 9, 1885</u>
9 AGE (In years last birthday) <u>81</u> yrs		10 UNDER 1 YEAR Months <u>19</u> Days <u>19</u>	11 UNDER 24 HRS Hours <u>19</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11 BIRTHPLACE (State or foreign country) <u>Germany</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Gottfried Stuhlfauth</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Diehl</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u> <u>Unknown</u>	
16 SOCIAL SECURITY NO <u>Unknown</u>		17 INFORMANT <u>Mr. Alwin Ohler (son)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fracture</u> DUE TO (c) <u>fracture</u>		INTERVAL BETWEEN ONSET AND DEATH <u>fracture</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED <u>5-5-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 23, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film 33.7 6/16/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06413

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) GLFN BURNIE c. LENGTH OF STAY IN 1b 30-4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 321 Mount Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN H. STUKES		4 DATE OF DEATH Month May Day 13 Year 1966	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1918
9 AGE (In years last birthday) 48 yrs.		10 IF UNDER 1 YEAR Months 48 Days 48 Hours 48 Min. 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY South Carolina	
11 BIRTHPLACE (State or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Stukes		14. MOTHER'S MAIDEN NAME Elizabeth Bowman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT George Stukes 321 N. Mount St.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple traumatic injuries 8244 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject was passenger in auto and was thrown from same.	
20c. TIME OF INJURY Month Day, Year Hour a.m. 5-13- 1966 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore, Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breiteneker, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 5-13-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/66	
23c. NAME OF CEMETERY OR CREMATORY Gum Spring		23d. LOCATION (City or Town) (County) (State) Summerton, S.C.	
24. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.		25a. REC'D BY REGISTRAR MAY 16 1966	
25b. REGISTRAR'S SIGNATURE Charles Young			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

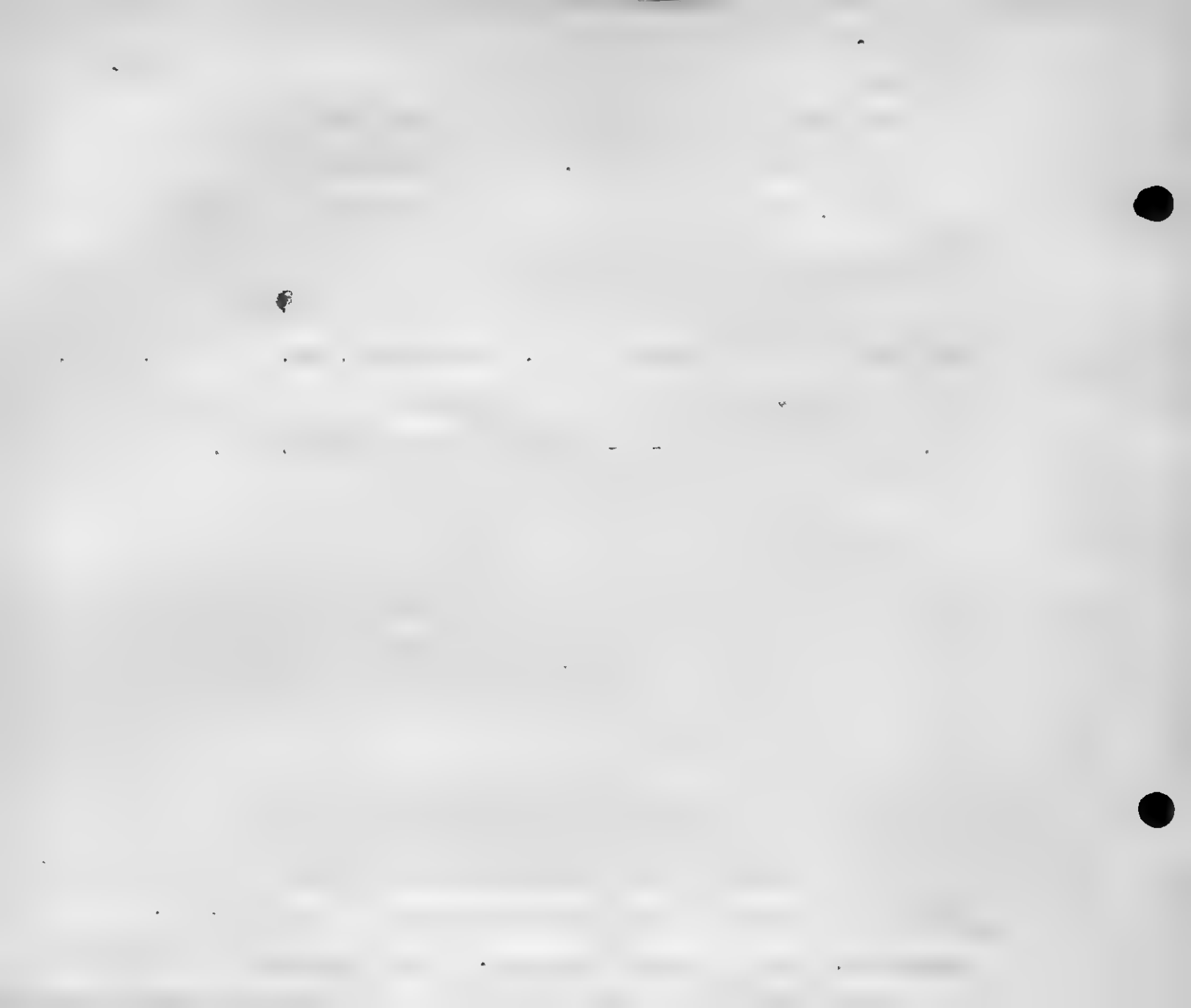
06417

06414

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b 1 yr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 200 St. James Place				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Brooklyn c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 4110 Orchard Avenue d. STREET ADDRESS 4110 Orchard Avenue			
3. NAME OF DECEASED (Type or print) William Thomas Sweeney		4. DATE OF DEATH Month May Day 14 , Year 1966		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/1897	9. AGE (In years birth day) 69 yrs.	IF UNDER 1 YEAR Months 6 Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY City of Balto.		11. BIRTHPLACE (County & State, or foreign country) Rock Creek, Md.			
13. FATHER'S NAME Thomas Sweeney		14. MOTHER'S MAIDEN NAME Stewart		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. 214-26-6513		17. INFORMANT Rosemary Barden			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 1548 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cancer of the rectum (c) 6 months DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Hour 19 e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from Feb. 16, 1966 to May 14, 1966 that (I) (#) last saw the deceased alive on May 13, 1966 and that death occurred at 4:40 P.M. the causes and on the date stated above.							
22a. SIGNATURE <i>Raymond C. Fink</i>		22b. DATE 5/16/66		22c. PHYSICIAN'S NAME (Type) Ilse Penbauer, M.D.			
22d. ADDRESS 936 Patapsco Ave., Baltimore, Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/66		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery			
23d. LOCATION (City, town or county) Brooklyn, Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Fink		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR MAY 18 1966			
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

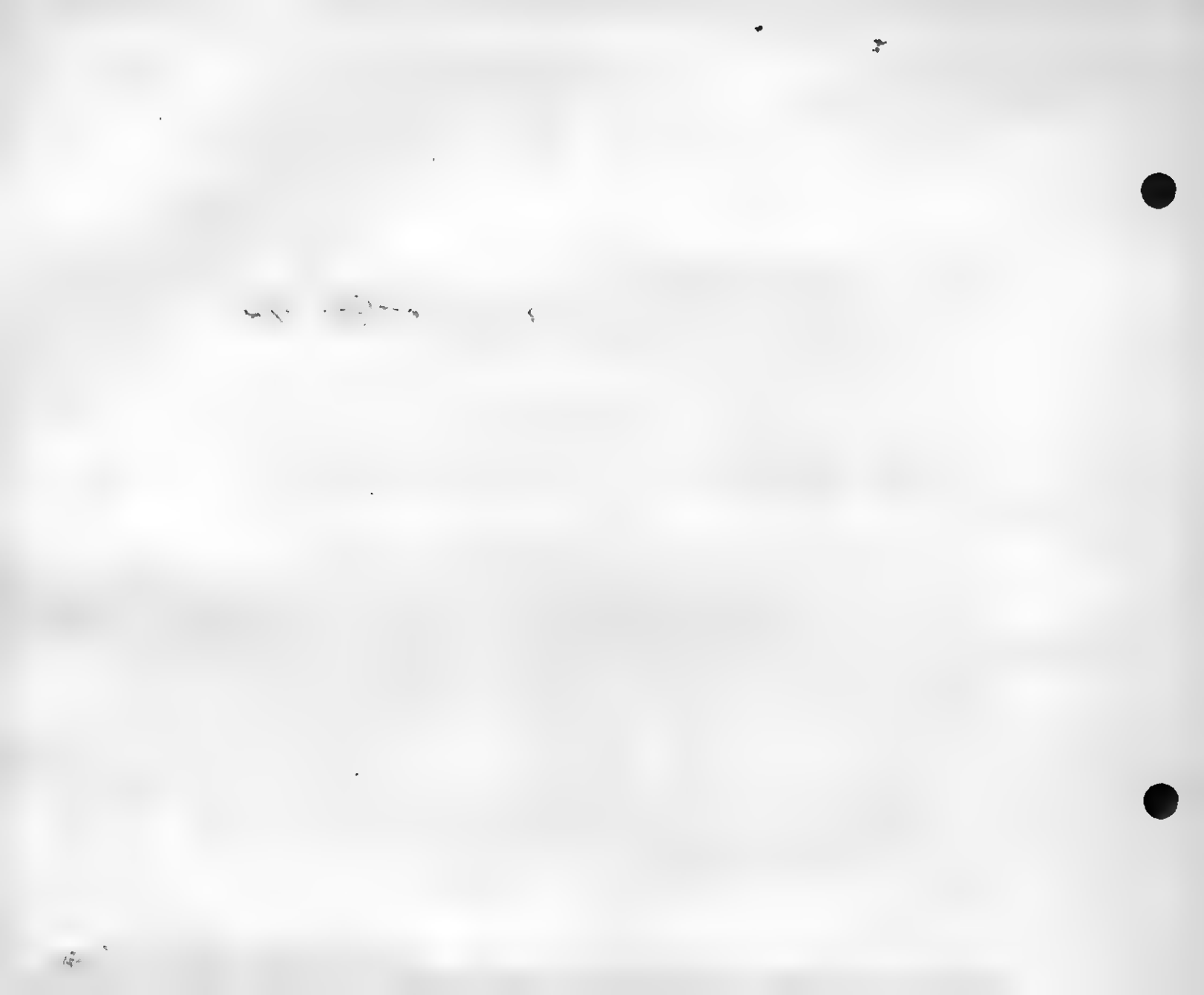
06418

06415

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN <u>4 1/2 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward N.M.N. Tydings</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5th</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Kitchen</u>		11. BIRTHPLACE (Country & State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>R12-184561</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident.</u> 391X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis.</u> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> , 19 <u>66</u> , to <u>5/8</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5/8</u> , 19 <u>66</u> , and that death occurred at <u>4:45 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Alvin Thompson</u> M.D.		22b. DATE SIGNED <u>5/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alvin Thompson</u>		22d. ADDRESS <u>Crownsville State Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAY 11-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PINE LAWN</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS - Md.</u>
24. FUNERAL DIRECTOR <u>C.E. Hicks</u> ADDRESS <u>Hicks Funeral Home, W. Street, Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 13 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



06419

CERTIFICATE OF DEATH

06416

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-2, Box-240	
3. NAME OF DECEASED (Type or print) Allen Pattison VANE		4. DATE OF DEATH Month May Day 8 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1906
9. AGE (In years last birthday) 59 yrs		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teacher	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Allen Vane		14. MOTHER'S MAIDEN NAME Leah Vane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 1-10-100000-10000	
17. INFORMANT Edwin Davis, Jr.		Address 100 Cathedral St., Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Rectum 154 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases DUE TO (c) metastases			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) Edwin Davis, Jr. attended the deceased from Feb. , 19 66 , to May 8 , 19 66 , that (I) (we) lost the deceased alive on May 8 , 19 66 , and that death occurred on May 8 , 19 66 , from causes and on the date stated above.			
22a. SIGNATURE Edwin Davis, Jr.		22b. DATE SIGNED May 9, 1966	
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr. M.D.		22d. ADDRESS 100 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5-11-66	23c. NAME OF CEMETERY OR CREMATORY Forest Hill	23d. LOCATION (City or town) (County) (State) Annapolis, Md.
24. FUNERAL DIRECTOR Charles Judge		25. REC'D BY REGISTRAR MAY 12 1966	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

06420

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06417

1 PLACE OF DEATH a COUNTY <u>A.A.Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not within Residence before admission) a STATE <u>MD</u> b COUNTY <u>A.A.Co</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater - Annapolis</u>		c LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.O.A - Anne Arundel General</u>		d STREET ADDRESS <u>Box 116 Mayo P.O.</u>	
3 NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>F</u> Last <u>VAUGHN</u>		4 DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 7, 1904</u>
9 AGE (In years last birthday) <u>61</u> yrs		10 IF UNDER 1 YEAR Months <u>18</u> Days <u>16</u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		11b KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11c BIRTHPLACE (State or foreign country) <u>Ohio</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles D. Vaughn</u>		14 MOTHER'S MAIDEN NAME <u>Elma Fulton</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>215 05 8617</u>	
17 INFORMANT <u>Pearl G. Vaughn Same as #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun shot wound Head</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Large spleen found</u>			
19a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		19b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Large spleen found</u>	
20c TIME OF INJURY Month Day Year <u>5/19/66</u>		20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>		20f (City or town) (County) (State) <u>AA Co MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D.	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		22. DATE SIGNED <u>5/19/66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5/21/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Et. Lincoln</u>		23d LOCATION (City or Town) (County) (State) <u>Colmar Manor Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>		25a REC'D BY REGISTRAR <u>MAY 23 1966</u>	
		25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

06421

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06418

1 PLACE OF DEATH a COUNTY AACo. MARYLAND		2 USUAL RESIDENCE (Where deceased lived if inst. on Residence before admission) a STATE Md b COUNTY DC.	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (if not in hosp. to give street address) D.O.A. - ANNE ARUNDEL CO.		e STREET ADDRESS 654 Girard St. N.W.	
3 NAME OF DECEASED (Type or print) John W. Wall		4 DATE OF DEATH Month 5 Day 7 Year 1966	
5 SEX M	6 COLOR OR RACE N	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-7-1906
10a USUAL OCCUPATION (Give kind of work done in most of working life, even if retired) U.S. Govt Supervisor		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 60 yrs
11 BIRTHPLACE (State or foreign country) Rankin, Pa		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Unknown		14 MOTHER'S MARRIAGE NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 239 14 5664	
17 INFORMANT (Name) Inez T. Wall		Address 654 Girard St N.W D.C.	
18 CAUSE OF DEATH (Enter only one cause per part for (a), (b) and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cholera disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1344	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)	
20c TIME OF INJURY Month, Day Year Hour o m p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. L. Whorl		22. DATE SIGNED 5-7-66	
EXAMINER'S NAME (Type) E. L. Whorl		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/11/1966	23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial CEM	23d LOCATION (City or Town) (County) (State) Su1tland PG, Co Md
24 FUNERAL DIRECTOR William Spangler - 524-8-51 NE		25a REC'D BY REGISTRAR MAY 11 1966	
25b REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06422

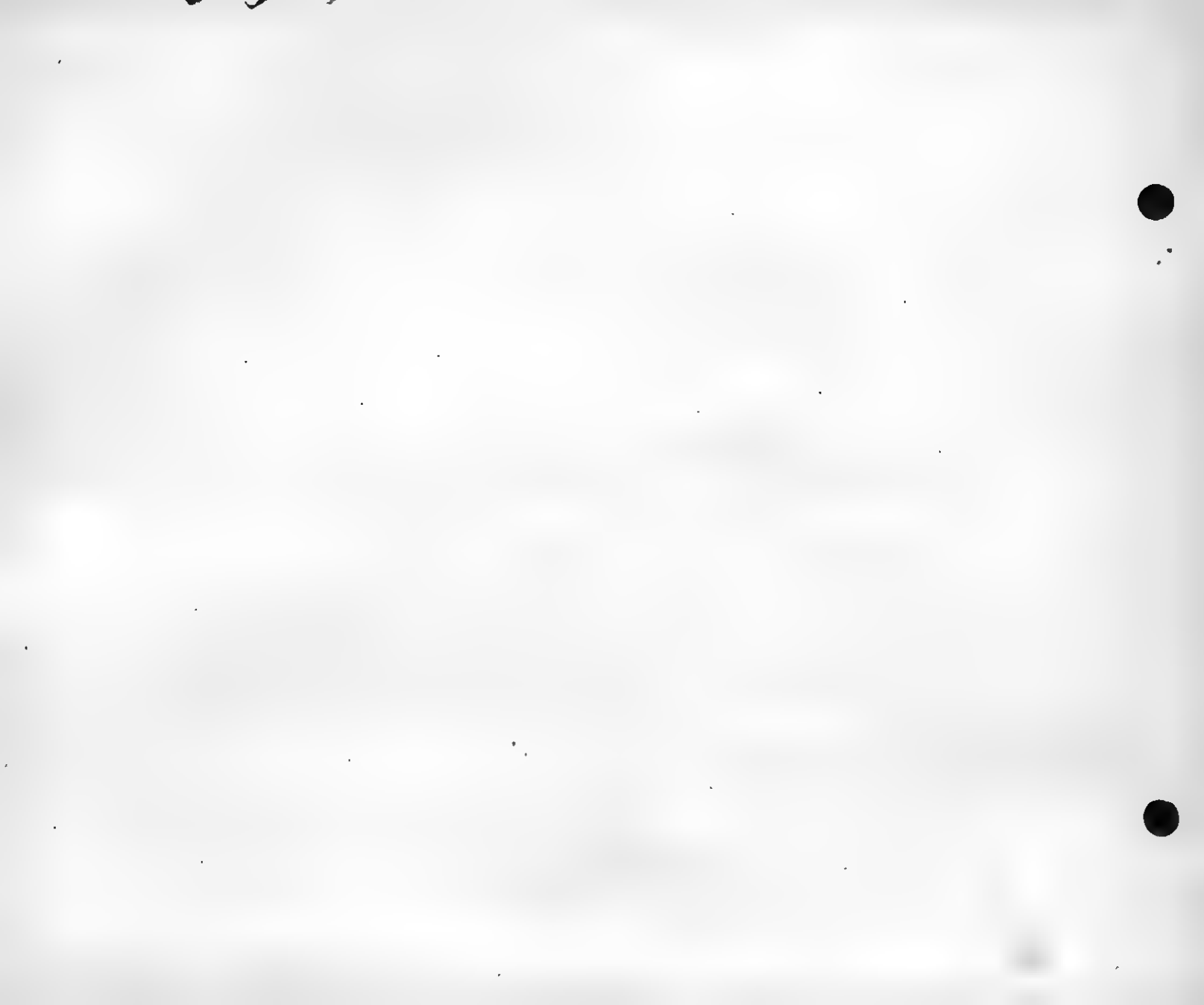
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06419

1 PLACE OF DEATH a. COUNTY <u>ANCO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANCO - 7/10 B. 25</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bald 25</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>5120 Brookwood Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>M.</u> Last <u>Walton</u>		4 DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1966</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 14, 1934</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engl. Southern Natl Co op</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engl. Southern Natl Co op</u>	9. AGE (In years last birthday) <u>32</u>
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Walton</u>		14 MOTHER'S MARDEN NAME <u>Ruth Lee</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOC. A. SECURITY NO.	
17 INFORMANT <u>Family</u>		Address <u>Same</u>	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>974 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVA. BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Strong reflex from tone</u>	
20c. TIME OF INJURY Month Day, Year <u>5/28 1966</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street office bldg etc) <u>1110 - AVE</u>	20f. (City or town) (County) (State) <u>ANCO MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Howard</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Howard</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-1-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Bald 25</u>	
24 FUNERAL DIRECTOR <u>Mc Culley Funeral Home</u>		25a. REC'D BY REG STRIP <u>JUN 3 1966</u>	
ADDRESS <u>237 Pat... Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

66420

VR A15 (4)
20M 1/65



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

86421

1. PLACE OF DEATH
a. COUNTY *Anne Arundel* MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Annapolis*
c. LENGTH OF STAY IN b. *Annapolis*
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) *528-4th St.*
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE *Maryland* b. COUNTY *AA*
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Annapolis*
d. STREET ADDRESS *528-4th St.*
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) *John Wells*
4. DATE OF DEATH *5 3 1966*
5. SEX *M* 6. COLOR OR RACE *Col.* 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH *3/11/1902*
9. AGE (In years last birthday) *64* yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Retired* 10b. KIND OF BUSINESS OR INDUSTRY *Maryland* 11. BIRTHPLACE County & State, or foreign country *U.S.A.*
12. CITIZEN OF WHAT COUNTRY? *U.S.A.*
13. FATHER'S NAME *Unknown* 14. MOTHER'S MAIDEN NAME *Emma Wells*
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) *Marie F. Wells - Annapolis, Md.* 16. SOCIAL SECURITY NO. 17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Pneumonia*
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. *Carcinoma of the lung with metastases*
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 *March 18, 1966* 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *Hahn Prof Bldg., Severna Park, Md.* 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from *March 18, 1966* to *May 3, 1966*, that (I) (we) last saw the deceased alive on *May 1st, 1966*, and that death occurred at *...* M, from the causes and on the date stated above.
22a. SIGNATURE *Ray M. Smith* M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) *Ray M. Smith, M.D.* 22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF *Burial 5/7/1966* 23c. NAME OF CEMETERY OR CREMATORY *Brewer Hill* 23d. LOCATION (City, town or county) (State) *Annapolis, Md.*
24. FUNERAL DIRECTOR'S SIGNATURE *William Reese, Jr. - Annapolis, Md.* ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DATE *MAY 5 1966* *Charles J. Jones*

1M
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06425 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06422

1. PLACE OF DEATH a. COUNTY <u>PR CO</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>528 4th St</u>		2. USUAL RESIDENCE (Where deceased lived, if inst. funeral residence before admission) e. STATE <u>MD</u> f. COUNTY <u>PR CO</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie</u> First Middle Last <u>7</u> 4. DATE OF DEATH Month Day Year <u>5</u> <u>20</u> <u>1966</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>Col</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 1, 1900</u> 9. AGE (In years last birthday) <u>65</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Bias</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Smothers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>3-12-66</u> 17. INFORMANT <u>Carrie Alvin Wallace</u> Address <u>123 X</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Depression & V. Chum</u> Conditions, if any, which gave rise to immediate cause (b) <u>Depression</u> (a), stating the underlying cause last, (c) <u>Depression</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Depression</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>5/20/66</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5/24/1966</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> 22d. LOCATION (City, town, or county) (State) <u>Annapolis, MD</u>		23. FUNERAL DIRECTOR <u>William Reesett</u> Address <u>Annapolis, MD</u> 24a. REC'D BY REGISTRAR <u>Charles Judge</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PMA-1. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 23 1966

CERTIFICATE OF DEATH

06423

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Shadyside	
3. NAME OF DECEASED (Type of print) First Middle Last George Henry WICKS		4. DATE OF DEATH Month Day Year May 13 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1913
9. AGE (in years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 13 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Wicks		14. MOTHER'S MAIDEN NAME Mary Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-07-1123	
17. INFORMANT Shirley Solisberry		Address Shadyside	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto balancing is affency DUE TO (b) Labor pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Days Days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 11 , 19 66 , to May 13 , 19 66 , that (I) (we) last saw the deceased alive on May 13 , 19 66 , and that death occurred at 11:20 P.M. M, from causes and on the date stated above.			
22a. SIGNATURE Gerard Chur		22b. DATE SIGNED 5/14/66	
22c. PHYSICIAN'S NAME (Type) Gerard Chur		22d. ADDRESS 121 CHATEAUX ST ANNAPOLIS MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 15-18-66	23b. DATE THEREOF 5-18-66	23c. NAME OF CEMETERY OR CREMATORY St. Matthews	23d. LOCATION (City or Town) (County) (State) Shadyside MD.
24. FUNERAL DIRECTOR William Reese		25a. REC'D BY REGISTRAR MAY 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

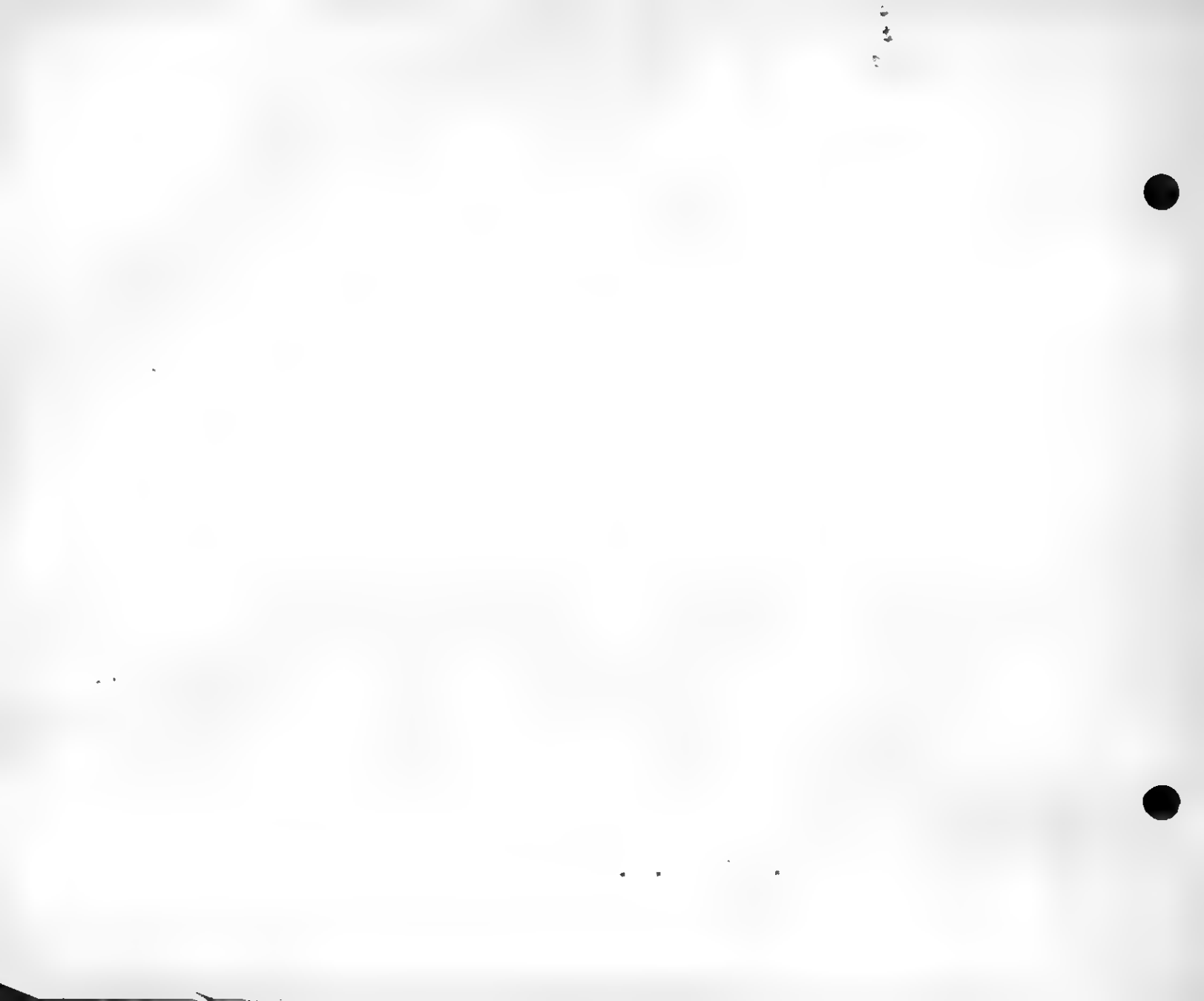
MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
06427		CERTIFICATE OF DEATH	
06424			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Lothian	
3. NAME OF DECEASED (Type or print) First Mary Middle ELIZABETH Last WILEN		4. DATE OF DEATH Month May Day 16 Year 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1874
9. AGE (in years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer		10b. KIND OF BUSINESS OR INDUSTRY Dry Goods	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William H. Wilen		14. MOTHER'S MAIDEN NAME EMMA MAC LEA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. J. Leslie Basil Address Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) years		INITIALS BETWEEN ONSET AND DEATH 36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 64 , to May 15 , 19 66 that (I) yes last saw the deceased alive on May 15 , 19 66 , and that death occurred at 1:15 AM , from causes and on the date stated above.			
22a. SIGNATURE Willard F. Smith		22b. DATE SIGNED 5/16/66	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.		22d. ADDRESS Shady Side, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-19-66	
23c. NAME OF CEMETERY OR CREMATORY GREEN Hill		23d. LOCATION (City or Town) (County) (State) Martinsburg W. Va.	
24. FUNERAL DIRECTOR John M. Gb + Sons		25a. REC'D BY REGISTRAR MAY 18 1966	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 7 Film 3-16 5/16/66 mh													
06428						MEDICAL EXAMINER'S CERTIFICATE OF DEATH						06425	
1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>North Carolina</u> COUNTY							
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilkesboro N.C.</u>							
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North arundel Hospital</u>						d STREET ADDRESS <u>Route 2 Box 109</u>				e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>R</u> Last <u>WILKINS</u>						4 DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>19 66</u>							
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>3, 31, 38</u>		9 AGE (in years last birthday) <u>28</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>66</u> Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11 BIRTHPLACE (State or foreign country) <u>Ellicott City, Md</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Clyde Wilkens</u>						14 MOTHER'S MAIDEN NAME <u>Leona</u>							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16 SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Clyde Wilkens, SAME AS 2</u>						Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of aorta</u> <u>8169</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Blunt force injury of chest</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury, in Part or Part of item 18) <u>Driver of automobile involved in head on collision.</u>									
20c TIME OF INJURY Month Day Year <u>Ham</u> Hour <u>5</u> m <u>7</u> p.m. <u>19 66</u>				20d INJURY OCCURRED While <input type="checkbox"/> at work or While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, off highway, etc.) <u>street</u>		20f (City or town) (County) (State) <u>Anne Arundel Md</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Werner U. Spitz, M.D.</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>May 8 66</u>			
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
Address (Street, city, town, or county)													
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b DATE THEREOF <u>8 May 66</u>		23c NAME OF CEMETERY OR CREMATORY <u>MILNER Funeral Home</u>				23d LOCATION (City or Town) (County) (State) <u>Wilkesboro N.C.</u>			
24 FUNERAL DIRECTOR <u>KIRKLEY Funeral Home</u>						ADDRESS <u>Glen Burnie, Md</u>		25a REC'D BY REGISTRAR <u>MAY 11 1966</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			



VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
- CERTIFICATE OF DEATH											
06426											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 2 Hours 20 Min d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital, Annapolis, Md.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ft. Meade b. COUNTY Maryland c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ft. Meade, Maryland d. STREET ADDRESS 7338 Kelley-Loop, Fort Meade Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Baby Boy WILLIAMMEE					4. DATE OF DEATH Month May Day 16 Year 19 66						
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 May 1966		9. AGE (in years last birthday) 2 yrs. 2 Min. 20			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -					10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) USNH, Annapolis, Md		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Otto Edwin WILLIAMMEE					14. MOTHER'S MAIDEN NAME Barbara Bangs						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service) -					16. SOCIAL SECURITY NO. -					17. INFORMANT (Father) Otto E. WILLIAMMEE Address 7338 Kelley Loop Ft. Meade, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Prematurity 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 16 May , 19 66 , to 16 May , 19 66 that (I) (we) last saw the deceased alive on 16 May , 19 66 , and that death occurred at 16 May from the causes and on the date stated above.											
22a. SIGNATURE C. B. HARGROVE					22b. DATE SIGNED 16 May 1966						
22c. PHYSICIAN'S NAME (Type) C. B. HARGROVE LCDR, MC, USN USNH, ANNAPOLIS, MARYLAND					22d. ADDRESS East MAHoning Church COMMODORE Pa.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 5-19-66		23c. NAME OF CEMETERY OR CREMATORY East MAHoning Church COMMODORE Pa.				
24. FUNERAL DIRECTOR John M. Lyle & Sons Annapolis, Md.					25a. REC'D BY REGISTRAR MAY 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

CERTIFICATE OF DEATH

06430

06427

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annapolis	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d STREET ADDRESS 39 Johnson Place	
3 NAME OF DECEASED (Type or print) Thomas WILSON		4 DATE OF DEATH Month May Day 19 Year 1966	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH September 11, 1912
9 AGE (In years last birthday) 53 yrs		10 IF UNDER 1 YEAR Months 53 Days 0 Hours 0 Min 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b KIND OF BUSINESS OR INDUSTRY Maryland	
11 BIRTHPLACE (County & State, or foreign country) U.S.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME William Wilson		14 MOTHER'S MAIDEN NAME Mary Hawkins	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. Release R. Wilson 39 Johnson	
17 INFORMANT Release R. Wilson 39 Johnson		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Circumstances Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Hypertension (b) Heart (c) Heart		INTERVAL BETWEEN ONSET AND DEATH Days 2 Years 1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from May 14, 1966 , to May 19, 1966 , that (I) last saw the deceased alive on 5/18 1966, and that death occurred at 10:15 P.M. from causes and on the date stated above			
22a. SIGNATURE Forced Blood		22b. DATE SIGNED 5/20/66	
22c. PHYSICIAN'S NAME (Type) Gorman P. H. H.		22d ADDRESS 121 Cathedral St., Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial 5-25-66	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY Brewer Hill Annapolis Md	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR William Reese # Annapolis		25a REC'D BY REGISTRAR MAY 23 1966	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06432

06428

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY in 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5 MURRAY AVE.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>5 MURRAY AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN D. WINN Jr.</u>		4. DATE OF DEATH Month Day Year <u>5 2 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1908</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>Norfolk, Va.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. C.G. Ret. Capt.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN D. WINN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH GERARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES 1 WW II</u>		16. SOCIAL SECURITY NO. <u>252-01-6558</u>	
17. INFORMANT <u>LAMAR C. WINN #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitotic Carcinomatosis</u> 1714 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>1714</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Annapolis</u>		20g. (County) <u>A.A. Co.</u>	
20h. (State) <u>MD.</u>		20i. (City or town) <u>Annapolis</u>	
20j. (County) <u>A.A. Co.</u>		20k. (State) <u>MD.</u>	
21. I certify that (I) (the hospital) attended the deceased from <u>1965</u> to <u>1966</u> that (I) (we) last saw the deceased alive on <u>1965</u> and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>W. L. Stephens</u> M.D.	
22b. DATE SIGNED <u>5-3-66</u>		22c. PHYSICIAN'S NAME (Type) <u>W. L. Stephens</u>	
22d. ADDRESS <u>38 Cornhill Annapolis</u>		22e. REC'D BY REGISTRAR <u>Charles Judge</u>	
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22g. DATE <u>MAY 4 1966</u>	
23a. DATE OF CREMATION <u>5-3-66</u>		23b. DATE THEREOF <u>5-3-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		23d. LOCATION (City, town or county) <u>Bladensburg</u> (State) <u>MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. ADDRESS <u>Annapolis, Md.</u>	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06432

06429

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> <u>3 yrs.</u> c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2 Eastpark Court</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ferndale, Glen Burnie</u> d. STREET ADDRESS <u>2 Eastpark Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elmer Jay Wrightstone</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 1, 1890</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>13</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>66</u>		4. DATE OF DEATH <u>May 13 1966</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME <u>Jonathon Wrightstone</u> 14. MOTHER'S MAIDEN NAME <u>Sara ?</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Evelyn B. Wrightstone, same as 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Carcinoma</u> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>1621</u> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3, 1960</u> to <u>May 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 13, 1966</u> , and that death occurred at <u>3</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis J. Glass</u> 22b. DATE SIGNED <u>May 14, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Louis J. Glass, M. D.</u> 22d. ADDRESS <u>320 Patapsco Avenue, Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>May 16, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Park</u> 23d. LOCATION (City, town or county) <u>Elkridge, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Kirkley Funeral Home, Glen Burnie, Md.</u> 25a. REC'D BY REGISTRAR <u>MAY 16 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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06433

CERTIFICATE OF DEATH

06430

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 30-4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>922 N. Calvert St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Jones</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-20-1879</u> 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>? - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Jones</u>				14. MOTHER'S MAIDEN NAME <u>Harriette Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Hospital Records Crownsville Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X PNEUMONIA</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/20/63</u> , 19__ to <u>5/21/66</u> , 19__, that (I) (we) last saw the deceased alive on <u>5/21/66</u> , 19__, and that death occurred at <u>9:07</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Hollie Sennaline</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5/21/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOLLIE SENNALINE</u>				22d. ADDRESS <u>Crownsville State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>MAY 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LODON PARK</u>		23d. LOCATION (City or town) (County) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>HARRY H. WITKE 4101 EDMONDSON AVE</u>				25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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INVESTIGATION UNIT

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[Faint, mostly illegible handwritten notes and signatures in the upper and middle sections of the document.]

[Handwritten signatures and notes in the lower section, including what appears to be a date "10/10/74" and a signature "H. A. ...".]

[Faint handwritten text at the bottom left corner.]

06436

CERTIFICATE OF DEATH

06431

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1306 Oak Road	
3. NAME OF DECEASED (Type or print) First Warren Middle Benjamin Last ZIKA		4. DATE OF DEATH Month May Day 12 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1899
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months 0 Days 12 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng.		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (County & State, or foreign country) Cleveland, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Anthony Zika		14. MOTHER'S MAIDEN NAME Alice Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World II		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Grace Zika		Address - Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and dehydration 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic bronchogenic carcinoma DUE TO (c) unk.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (do not) attended the deceased from Oct. , 19 65 , to May 12 , 19 66 , that (I) (had) last saw the deceased alive on May 12 , 19 66 , and that death occurred on May 12 , 19 66 , from causes and on the date stated above.			
22a. SIGNATURE Barber C. Palmer		22b. DATE SIGNED 5-12-66	
22c. PHYSICIAN'S NAME (Type) Barber C. Palmer, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-16-66	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Nat. Cemetery, Va.		23d. LOCATION (City or Town) (County) (State) Greenwood Nat. Cemetery, Va.	
24. FUNERAL DIRECTOR Robert S. Barrow, Severna Park, Md.		25. SIGNED BY REGISTRAR MAY 16 1966	
26. REGISTRAR'S SIGNATURE Charles Judge		27. DATE MAY 16 1966	

MEDICAL CERTIFICATION

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